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Review of the General Practice Education Programme Training Funding

**For Manatū Hauora/Ministry of
Health**

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Executive summary

There is no doubt about the importance of an effective primary healthcare system in Aotearoa New Zealand. There is considerable evidence that prevention, early intervention and treatment in primary care reduce the costs associated with other parts of the health sector.

General practitioners (GPs) have a core role in delivering primary care but the workforce is aging and access to a general practice is difficult for some communities. Increasing the numbers of GPs is important to strengthen the workforce.

Manatū Hauora/Ministry of Health has commissioned a review of the General Practitioner Education Programme (GPEP) funding model. GPEP has been delivered by the Royal New Zealand College of General Practitioners (RNZCGP – the College) through a funding agreement with MOH.

The specific question to be addressed through this review is whether the current GPEP contract supports the best outcomes for the recruitment and retention of the GP workforce. The review scope is the extent the GPEP funding model is an effective vehicle to attract registrars to GPEP and to enable a clinically and culturally competent GP workforce across Aotearoa New Zealand.

The focus of the review is only part of the GP registrar pipeline. The numbers of students including Māori and Pacific students entering Medical School, their Medical School and post-graduate experiences all influence their entry to GPEP.

The review has been informed by triangulation of information from document reviews, economic analyses, interviews with relevant organisations, and interviews and surveys with GPEP registrars, College fellows, medical educators and practices accredited to provide teaching placements.

Addressing the identified barriers requires responses that extend beyond the current scope of the funding model

Synthesis of information for the review has identified barriers to recruiting and retaining the GP workforce required for an effective primary healthcare system in Aotearoa New Zealand.

The Health System reforms provide a unique opportunity to respond to the review findings and develop innovative and more equitable approaches to building Aotearoa New Zealand's GP workforce. Forming new partnerships and strengthening existing partnerships provides the foundation for positive changes.

The recommendations below are premised on:

- Manatū Hauora obligations under Te Tiriti o Waitangi and the importance of achieving equitable outcomes for Māori
- Ensuring GPEP continues to offer flexible and part-time training options
- GPEP is funded from the public purse as other vocational specialities.

An equity lens is essential in considering the extent the GPEP funding model supports a culturally competent general practice workforce.

Achieving the *Whakamaua: Māori Health Action Plan*¹ outcomes, health sector obligations under Te Tiriti and the *Ola Manuia: Pacific Health and Wellbeing Action Plan*² outcomes provide context to the GPEP review and must be considered in responses to the review findings and recommendations.

There are inequitable outcomes for Māori and Pacific peoples in the current health system. Mana Taurite (Equity) must be reflected in the GPEP funding model, the employment model, support for registrars and in enabling opportunities for placements with kaupapa Māori providers³ for all registrars.

A culturally competent GP workforce that includes more Māori and Pacific GPs will contribute to breaking down barriers for Māori and Pacific to access general practice and receive culturally safe healthcare. Kōwhiringa includes resourcing Māori and Pacific general practices to become accredited teaching practices and supporting more Māori and Pacific GPs to be involved in teaching.

Tino Rangatiratanga and Pātuitanga (Partnerships) between health sector organisations and Māori are a Te Tiriti obligation and change will not be achieved without partnerships at national and regional levels.

Whakamarumarutia (Active Protection) requires ongoing monitoring and evaluation of strategies put in place to respond to the review.

¹ <https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity#:~:text=The%20Ministry's%20definition%20of%20equity,to%20get%20equitable%20health%20outcomes.>

² https://www.health.govt.nz/system/files/documents/publications/ola_manuia-phwap-22june.pdf

³ For the purpose of this review, we consider kaupapa Māori providers to be any provider guided by kaupapa Māori principles, tikanga and te ao Māori and with Māori governance. This includes iwi health providers.

Inhibitors within the current model that may be a barrier to improving the number and distribution of GP training and supply

General practice is seen in the health sector as a 'lesser' profession. Lack of positive GP role models in DHB settings in post-graduate years, perceptions of GPEP as less rigorous than other vocational training programmes and ability to practice as a GP without completing GPEP contribute to this perception.

A difference in income between general practice and hospital-based registrars was the most widely identified barrier to entering GPEP. Although base salaries for GPEP and DHB registrars may appear similar, the terms and conditions and the employment category effectively result in lower incomes for College employed GPEP 1 registrars. In DHB settings, registrars also have opportunities to bolster their incomes through overtime payments.

Combined with perceptions of general practice as a 'lesser' speciality, the income difference results in a workforce that prioritises flexibility and part-time training and/or is committed to community practice and primary care. Increases in the complexity of general practice, reports of high workloads, changes in the traditional model and reduced ability to generate incomes as practice owners all contribute to making general practice look a less appealing vocational choice.

Responding to recruitment barriers requires GPEP and DHB registrar incomes to be aligned alongside promoting general practice in Medical School and post-graduate settings. Aligning employment terms and conditions does not mean incomes would necessarily be the same for registrars across different vocational programmes but would provide transparency about the reasons for any differences, such as part-time or on call work. Incentives may also have a role to play in attracting doctors to general practice.

Separation of employer and educator roles is likely to enable standardisation of terms and conditions of GPEP registrar employment within GPEP, between GPEP and other vocational opportunities and provide transparency. Those we interviewed provided examples of a conflict between the College's current roles as an employer and an educator. From the College's perspective there are challenges in being responsible for the health and safety of registrars employed in different practices around the country.

Recommendation 1a: Te Whatu Ora/HNZ is the employer for GPEP registrars and GPEP registrars' salary and employment terms and conditions are aligned with registrars in other vocational programmes.

Equivalence may be most effectively achieved if GPEP registrars and registrars in other vocational training programmes have the same employer and employment contracts. Te Whatu Ora/HNZ was identified by interviewed stakeholders as the potential employer. GPEP registrar terms and conditions of employment would therefore be directly negotiated with the funder. Having a single employer would also address current challenges with GPEP 1 registrars employed by practices.

Employment by Te Whatu Ora/HNZ is also likely to enable inclusion of Te Aka Whai Ora/ Māori Health Authority in developing strategy and decisions about how best to support Māori registrars.

The College, as the professional body, would retain leadership of GP training, responsibility for the educational content and quality assurance, and pastoral care.

Recommendation 1b: General practice is promoted in the under-graduate and post-graduate years as an important and valuable vocational choice.

Promoting general practice requires health sector wide responses. While the College has a key role in promoting the profession, universities and the Medical Council of New Zealand must promote general practice and increase exposure to general practice in the undergraduate and post-graduate years. Post-graduate community practice attachments are an existing mechanism to promote general practice. Opportunities for community placements must be increased. Good experiences on community attachments and in other settings with positive GP role models are effective in promoting general practice.

Enabling a clinically competent general practitioner workforce

GPEP education funding is aligned to the first year of the programme. The current funding model drives the focus of most teaching components within the first year. This focus on the first year may contribute to perceptions the training programme is less rigorous than other vocational programmes.

In interviews and in response to the survey, current and past registrars, and GP teachers were positive about the GPEP 1 educational experiences. At the end of GPEP 1, except for record keeping, most registrars felt they had achieved the

required clinical competencies. They were less confident about consulting with Māori, Pacific and patients in rural communities.

There was general feedback from all groups that more support for registrars was needed in GPEP 2. Interviewed registrars described the current GPEP 2 seminars as too infrequent and as including too many participants. Registrars identified the need for more frequent and one on one or small group support focused on case reviews. Teachers discussed the benefits of moving the clinical component of the exam to the mid-point of GPEP 2 and the importance of supporting registrars who were struggling.

Teaching fellows and accredited practices provide placements for GPEP 1 registrars and would have a key role in any extension of the education programme into GPEP 2. There are currently more practices wanting to provide registrar placements than there are registrars. This creates uncertainty for practices about whether they will have a registrar or not. Uncertainty can be a barrier to a practice investing in accreditation, providing space within the practice or development of accommodation options for registrars. Providing certainty to practices and support to meet accreditation criteria is a strategy to respond to current gaps in availability of registrar placements with rural practices and Māori and Pacific practices.

Extension of the educational component of GPEP 2 has funding implications both for teaching time and for registrar employment. Aligning GPEP registrar employment with other vocational groups also requires consideration of options for GPEP 2 employment by Te Whatu Ora/HNZ. In most other vocational programmes, registrars are employed by the DHB for three or more years, with the duration often being five or six years. In general practice this is complicated by the potential for registrars to start to generate income for the practice as they gain experience. Although the amount they can generate is affected by many factors.

Recommendation 2a: Te Whatu Ora and the College work together to consider expanding the educational component of GPEP 2 and deferring the clinical exam until GPEP 2 and the associated funding implications.

The College, as the professional body, would lead the development and delivery of any changes in GPEP 2 support.

Recommendation 2b: Te Whatu Ora/HNZ and the College consider employment options for the educational component of GPEP 2.

Employment options should be considered alongside an extension of the GPEP 2 educational component. Options might include Te Whatu Ora/HNZ employment in part or full until after the clinical exam (adjusted by practice co-payment rates),

general practice subsidies for education time, and/or regional rotations (see below) that extend to GPEP 2.

In GPEP 3, registrars would be totally practice employed as they are at present.

Recommendation 2c. The funder and the College develop strategies to support wider representation of rural, Māori and Pacific practices to become accredited practices.

Recognising that providing registrar placements in VLCA practices and other practices with low co-payments may be a cost to the practices that needs to be covered as part of the funding model. Considering that there may be other ways to assess practice quality for accreditation.

Enabling a culturally competent and culturally safe workforce

A culturally competent workforce underpins health sector obligations to Te Tiriti principles of Mana Taurite (Equity), Whakamarumarutia (Active protection), and Kōwhiringa (options to receive culturally competent care).

Enabling a culturally competent workforce requires:

- Recruiting and retaining Māori and Pacific doctors to GPEP. The general practice workforce does not reflect the population it serves, with low participation from Māori and Pacific peoples. Barriers within the education system that result in lower NCEA 3 attainments by rangatahi Māori and Pacific young people affect the numbers who can enter Medical School. Medical School funding also influences the numbers of graduate doctors.
- Providing appropriate support to Māori and Pacific registrars. Rangatahi Māori and Pacific young people who do enter GPEP need to be supported in ways that recognise their contribution to a culturally competent general practice workforce. Current support for Māori and Pacific registrars relies on the goodwill and commitment of a small group of teachers and Māori and Pacific doctors.
- Building cultural competence and cultural safety amongst non-Māori and non-Pacific teachers and registrars.

The equity component to support and mentor Māori and Pacific registrars represents 2% of the operational component of the contract. Additional funding has been provided by Manatū Hauora to the College to provide cultural training for GP teachers and to extend the support for Māori and Pacific registrars. This is likely to improve support for Māori and Pacific registrars but was not in place when the review interviews were completed.

GPEP registrars attend noho marae as a two-day programme initiation. However, the most effective opportunities to develop cultural understandings for non-Māori and non-Pacific GPs is for them to live and work in communities with a high proportion of Māori and/or Pacific peoples. The current option of GPEP 1 employment directly with practices limits opportunities for the College to require registrars to complete placements in Māori, Pacific and rural localities.

Māori and Pacific GPs are under-represented in the teaching workforce. Under-representation reflects general under-representation in the GP workforce. Strategies are needed to involve Māori and Pacific doctors in teaching earlier in their careers to develop teaching skills and to adequately fund teaching time.

Māori and Pacific practices are under-represented in practices accredited to take registrars, including in districts with a high proportion of Māori communities.

There are accreditation barriers to becoming a placement provider for registrars. Increasing the number of Māori and Pacific accredited practices requires further examination of barriers and development of strategies to address identified barriers. Quality assurance is essential but the current requirements of Cornerstone accreditation, presence of a teaching fellow and the cost of being an accredited practice appear to be disadvantaging some types of providers such as very low cost access (VLCA) practices and Māori and Pacific providers.

Recommendation 3: Explore and address barriers to Māori and Pacific participation in GPEP training. For example by:

- Enabling Tino Rangatiratanga through ensuring a Māori voice in decisions about GPEP funding and content. Nationally, Te Aka Whai Ora/Māori Health Authority is the best placed organisation.
- Pātuitanga - Regional partnerships with mana whenua to strengthen registrar and teachers' cultural understandings and experiences. Cultural training for registrars can sit alongside the clinical training and does not need to be delivered by clinicians. A mana whenua approach will enable registrars to care for patients in a way that considers the community and context where whānau live.
- Strengthening the support for Māori and Pacific registrars. The additional funding provided by Manatū Hauora for registrar support may be sufficient.
- Building the Māori and Pacific teaching workforce and in the interim considering ways to include Māori and Pacific doctors in clinical teaching even if they have not achieved College fellowship.
- Enabling more representation of Māori and Pacific general practices as placement providers (see Recommendation 2c).

Regional training programmes have the potential to provide more effective coverage for training placements including for rural localities

While there are more placement providers than registrar, there is a lack of different practice types in some localities, registrars who do not want to relocate or who consider they have had insufficient time to plan for relocation, and the availability of a practice-employment option to avoid relocation.

Most other vocational programmes include mandatory rotation. These are largely planned and allow certainty for registrars. There is potential for a one or two-year GPEP regional programme to be developed.

- A regional programme could be developed as funded partnerships with mana whenua, PHOs and other primary care providers.
- Registrars could select a region and complete a programme that would include options within the region. Options could consider a registrar's ability to travel. We heard from registrars that adequate time to plan would make it easier for them to relocate.
- The regional programme might involve fewer general practices but provide more certainty to those that were involved. Certainty would enable practices to plan for a registrar and potentially increase enrolled patient numbers and capitation income.
- Other organisations and settings could be part of a regional rotation with appropriate supervision and guidance. For example, marae and workplace clinics, NGO services and rural hospital rotations.

Recommendation 4: Health sector organisations and the College consult with mana whenua and other regional partners to explore opportunities for regional placement programmes to extend coverage and improve cultural safety education and understanding of rural localities.

A regional pilot programme could be set-up and evaluated to inform national development.

Regional partnerships could build on partnerships started with Te Ahunga and the undergraduate interprofessional education initiatives.

Appropriate use of funding (within the allocated budget)

The GPEP contract comprises four components with budget allocated to each component. The transactional nature of the contract constrains new initiatives.

The commissioning model, contract management and funding must reflect equity. No one party can achieve the changes needed.

Recommendation 5: A reviewed GPEP funding contract with a focus on partnerships between health sector organisations to achieve change

The recommendations arising from the review will require substantial changes to the current GPEP contract. Achieving change will require the key sector stakeholders to work together to progressively address the issues raised in this review and to strengthen the GP workforce.

A change in the GPEP contracting relationship between Manatū Hauora and the College is required to work towards a high trust contracting model.

1. The Aotearoa New Zealand general practice context

General practice and other forms of primary care are important parts of Aotearoa New Zealand's primary healthcare system. Primary care is community based and the foundation of healthcare. Prevention and treatment in primary care takes the pressure off specialist health services.

Between 2008 and 2016, the number of GP consultations increased nearly 12%, which was higher than the population growth of 10.2% in the same period⁴. Complexity of community presentations in a primary care setting also continue to increase. The financial cost to patients coupled with health complexities result in patients presenting multiple problems in a 15-minute appointment. The current model of care is widely recognised as inadequate particularly for rural and high needs areas and contributes to high levels of burn-out.

General practice is becoming more and more time consuming to just do business as usual. (Survey data – Teacher)

Although most general practices operate as a privately owned business, there are other business models, ranging from the traditional owner-operator model to corporate ownership and NGO or Iwi models. There is an increasing focus on the wider primary care team, and upon the development of other models of primary care, such as nurse practitioner clinics.

A disproportionately lower number of Māori and Pacific general practitioners (GPs) compared to population proportions is a barrier to achieving equitable outcomes for Māori and Pacific communities. Challenges in recruiting Royal New Zealand College of General Practitioners (RNZCGP – the College) fellows to rural locations contributes to inequitable outcomes for those living in rural locations.

The 2020 general practitioner workforce survey⁵ noted the GP education intake needs to increase to develop a sustainable workforce.

4

https://www.health.govt.nz/system/files/documents/pages/health_workforce_funding_review_-_current_state_final_25_nov.pdf

5

https://www.rnzcgp.org.nz/RNZCGP/Publications/The_GP_workforce/RNZCGP/Publications/GP_workforce.aspx?hkey=a7341975-3f92-4d84-98ec-8c72f7c8e151

1.1. The General Practice Education Programme (GPEP)

The College is funded by the Manatū Hauora/Ministry of Health to deliver the three-year General Practice Education Programme (GPEP). Registrars are eligible to enter after two-years hospital-based post-graduate work. After 36 months of GPEP, registrars can be assessed and if they meet the standards they become a fellow of the College⁶.

1.2. GPEP 1

GPEP 1 is one intensive year of training in the work environment. Many registrars accepted for GPEP 1 are employed by the College for the first 12 months through funding provided by the Ministry contract with the College.

GPEP 1 registrars are based in general practices. Registrars who are College employed are required to complete two six-month placements. They spend on average one day each week in seminars and workshops under the guidance of medical educators (ME). They are required to undertake a range of activities as set down in the College's GPEP Programme Regulations.

Day to day support and mentorship is provided by a teacher in the practice. The practice must be accredited by the College to host a registrar and the teacher must be a fellow of the College.

1.3. GPEP 2/3

Registrars complete two subsequent years of supervised practice and additional learning (GPEP 2/3) employed directly by general practices. The aim of GPEP 2/3 is to provide an opportunity for registrars to refine their skills, knowledge and clinical practice with an emphasis on reflection. Registrars participate in group sessions approximately two-monthly. They undertake additional requirements and assessments as set down in the College's GPEP Programme Regulations, including completion of an academic component. They are expected to maintain a mentoring relationship with a fellow of the College.

The annual fee for GPEP years 2/3 is \$2,500 plus GST. At the completion of GPEP 1 registrars also begin paying membership fees to the College. On successful

⁶

https://www.rnzcp.org.nz/RNZCGP/Become_a_specialist/Become_a_General_Practitioner/General%20Practice%20Education%20Programme/GP_Education_Programme.aspx

completion of all the programme requirements there is a Fellowship assessment fee of \$2,100 plus GST.

1.4. Differences between general practice and other specialities

The GPEP funding model must be considered in the context of the training pipeline. Doctors mainly work in hospitals in their post-graduate years. They have access to monitoring and advice in hospital settings from senior medical staff, other registrars, and nurses. They have little exposure to positive general practice role models unless they do a community run in a general practice. Hospital-based registrar programmes are often closely integrated into service delivery, and represent a core part of the hospital workforce, supporting senior doctors in service delivery and providing significant elements of both daytime and out of hours care.

Several key differences apply to general practice that differ from hospital health care:

- The State pays around two-thirds of the cost of delivering general practice care. This is fundamentally different to fully funded public hospital care, and is in a different training setting that results in different issues for trainees. For example, trainees may be contractors rather than salaried staff.
- Doctors can provide general practice in the community under a general scope of practice. Fellowship, achieved via the registrar programme, brings no additional remuneration or formal seniority for those who become Fellows of the College, beyond peer recognition from immediate colleagues.

Many issues for general practice in Aotearoa New Zealand are similar to other international jurisdictions. For example, general practice is typically privately owned in both the United Kingdom and Australia, and issues of rurality are important for general practice in many parts of the world.

2. The GPEP Review

Manatū Hauora has requested a formal evaluation of the GPEP funding model to:

- Identify if the current contract appropriately supports the GPEP to improve the number and distribution of training and supply, and future sustainability
- Identify any inhibitors within the current model that may be a barrier to improving the number and distribution of GP training and supply.
- Provide any recommendations for improvements to the contract.

The specific question to be addressed through the evaluation is whether the current GPEP contract supports the best outcomes for the recruitment and retention of the GP workforce including:

- Responsiveness and compliance with Te Tiriti o Waitangi obligations
- An emphasis on equity that will intensify the response to the recognised GP workforce challenges
- Appropriate use of funding (within the allocated budget)
- How registrars on the training programme should be employed
- How to access the most effective coverage for training placements.

The last review of GPEP was in 2010-12 to revise the curriculum content and establish an employment model for GP registrars.

2.1. The scope of the review

GPEP funding influences the entry of post-graduates into GPEP and the delivery of GPEP training and placement provision by the RNZCGP. The extent GPEP funding enables entry to GPEP and the RNZCGP to produce clinically and culturally competent GPs is the focus of the review. However, it is important to also acknowledge other parts of the training pipeline such as the number of Māori and Pacific students entering medical schools, the extent they are enabled by other factors to enter GPEP training and wider socio-economic determinants of health also influence health outcomes.

The figure below highlights the scope of the GPEP review.

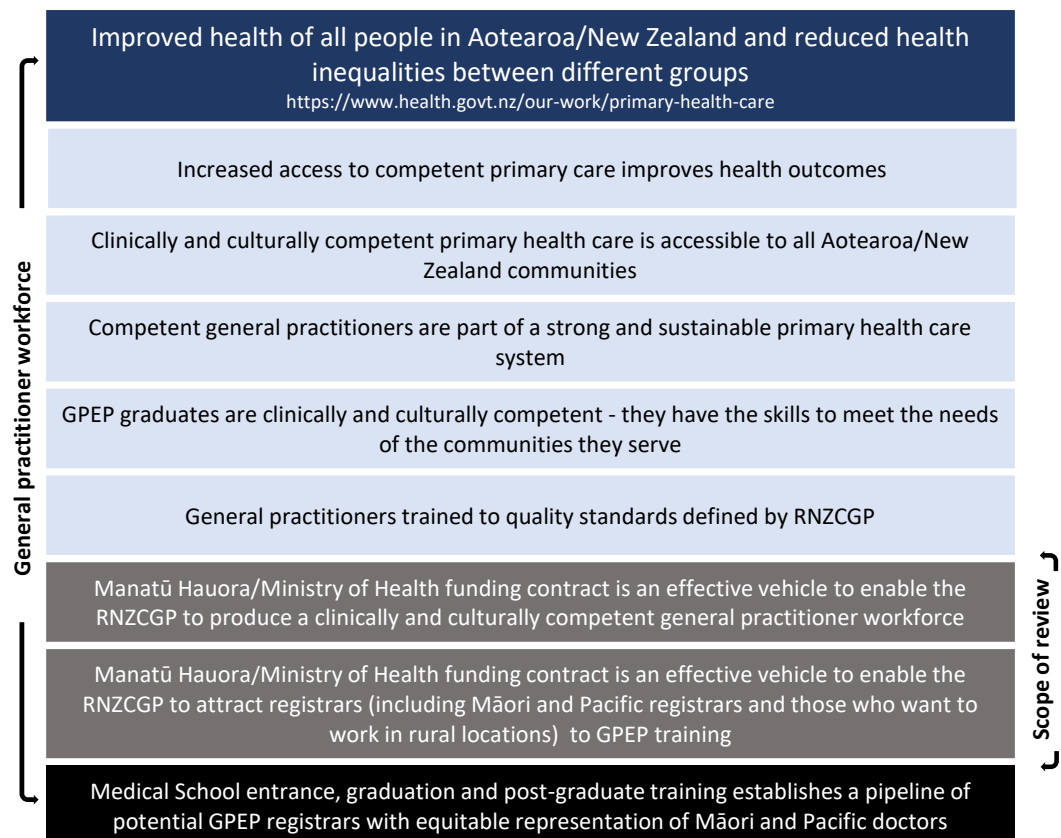


Figure 1. The scope of the GPEP review in the general practitioner training pipeline

2.2. Approach to the review

A draft scope of work, review questions and review framework were developed to provide a theoretical foundation for the evaluation. Development was based on interviews with representatives from the Manatū Hauora team including the Māori and Pacific Directorates, the Chief Nurse and the Primary Care Directorate as well as the College.

The drafts were presented and discussed at a workshop of key stakeholders with the aim of ensuring a shared understanding of the review scope and information that will be used to inform the review. These were revised to include feedback received.

2.3. Information sources for the review

The review drew information from documents, analysis of administrative data from Manatū Hauora and RNZCGP, in-depth interviews, analysis of information from surveys (detailed in Appendix Two), and analysis of information about the costs of GPEP.

Table 1. Information sources for the review

Information source		
Documents	GPEP contract and College contract teacher template	
Administrative data	2015-2020 Registrar cohort data provided by the College Current teacher and accredited practice data provided by the College MCNZ register data – analysed by the Manatū Hauora team	
In-depth interviews – a small number were completed in focus groups	RNZCGP: CEO, President, Pou Whirinaki, clinical leads (2), Pacific chapter representative Organisations: Rural General Practice Network, Censor-in-Chief, GP NZ, NZRDA, DHBs (x2), TAS, MCNZ, PHO NHC were invited to participate but did not respond. Teachers: x6 ME: x5 GP registrars: x9 Accredited practices: x4 Māori provider Pacific provider	
Surveys	GPEP RMO – sent by NZRDA	190 (9%)
	GPEP registrars including 20 current GPEP 1, 71 who had completed GPEP 1, 125 who had completed GPEP 2, 172 fellows, 13 on hold, 3 discontinued and 11 other definitions. Survey responses were received from 33 Māori and 12 Pacific current or past-registrars ⁷ .	415 (25%)
	GP teacher (RNZCGP Fellow)	168 (36%)
	GPEP accredited practice	44 (24%)

Interviews were analysed thematically to identify key themes. Survey data were analysed descriptively.

The economic analysis drew on contract analysis and information held by Sapere about the costs of general practice. Information from the surveys about supervision time, registrar consultation times and numbers of patients seen informed the economic analyses.

⁷ Māori and Pacific current and past registrars responded to the survey in the approximately the same proportions as those from non-Māori and non-Pacific ethnic groups.

2.4. Strengths and limitations

The review was strengthened by triangulation of information gathered from different sources and perspectives and by the willingness of those invited to participate in interviews and the survey.

The survey responses were adequate and the profile of respondents aligned with the sampling frame. While a slightly higher proportion of female registrars completed the registrar survey than male registrars, weighting of the results did not materially alter the findings.

There were some limitations to the review:

- Completion data were limited because of the time frame over which GPEP training could be completed including deferments.
- We had contact details for current registrars, teacher and accredited practices but were not able to survey those who may have wanted to be a placement provider but did not meet eligibility criteria.

3. The GPEP Funding Model

Key messages

The contract comprises four components of the contract which reflect the key aspects of GPEP delivery. The contract structure and inability to move money from one component to another limit responsiveness and flexibility.

The equity component to support and mentor Māori and Pacific registrars represents 2% of the operational component of the contract⁸.

Opportunities:

A balance between the current transactional contract and an outcomes focused contract that allows more flexibility to move money between contract components.

Inclusion of perspectives from Manatū Hauora and College policy teams and consultation with Māori could strengthen the contract content and improve the extent Manatū Hauora is meeting its obligations under Te Tiriti o Waitangi.

3.1. Equity and Te Tiriti o Waitangi

Manatū Hauora has obligations under Te Tiriti o Waitangi (Te Tiriti). Meeting those obligations through the GPEP contract is necessary if the Ministry is to realise the overall aims of He Korowai Oranga: Māori Health Strategy and achieve equitable outcomes for the health and disability system as a whole.

The Ministry's Te Tiriti obligations underpin *Whakamaua: Māori Health Action Plan 2020–2025* which sets the government's direction for Māori health advancement over the next five years. The Ministry recognises that 'Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes'.

Whakamaua focuses on four high-level outcomes to realise the vision of pae ora⁹:

⁸ Additional funding has been provided by Manatū Hauora to the College to provide cultural training for GP teachers and to extend the support for Māori and Pacific registrars. This is likely to improve support for Māori and Pacific registrars but was not in place when the review interviews were completed.

⁹ <https://www.health.govt.nz/our-work/populations/maori-health/whakamaua-maori-health-action-plan-2020-2025>

- Iwi, hapū, whānau and Māori communities can exercise their authority to improve their health and wellbeing.
- The health and disability system is fair and sustainable and delivers more equitable outcomes for Māori.
- The health and disability system addresses racism and discrimination in all its forms.
- The inclusion and protection of mātauranga Māori throughout the health and disability system.

*Ola Manuia: The Pacific Health and Wellbeing Action Plan*¹⁰ is a tool for the health sector when they are planning and delivering health and disability services for Pacific peoples in Aotearoa New Zealand. It emphasises the need for a whole of government approach to achieving equitable health and wellbeing outcomes for Pacific peoples.

Achieving the *Whakamaui* and *Ola Manuia* outcomes and Manatū Hauora obligations and aims provide context to the GPEP review and must be considered in the Ministry and College's response to the review findings and recommendations. Equity must be reflected in the GPEP funding model, the employment model and in training placements¹¹.

3.2. The GPEP contract

The 2021 GPEP contract is comprised of four components:

- Component 1: Salaries and direct costs. As more registrars move to practice employment the registrar salary costs to the College and Manatū Hauora decrease.

Components 2, 3 and 4 are the operational components of the contract¹²

- Component 2: Programme delivery. College training and administration cost to deliver the programme including all the costs associated with Medical Educators and Fellows. This component also includes funding to support

¹⁰ https://www.health.govt.nz/system/files/documents/publications/ola_manuia-phwap-22june.pdf

¹¹ <https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity#:~:text=The%20Ministry's%20definition%20of%20equity,to%20get%20equitable%20health%20outcomes.>

¹² Additional funding has been provided by Manatū Hauora to the College to provide cultural training for GP teachers and to extend the support for Māori and Pacific registrars. This is likely to improve support for Māori and Pacific registrars but was not in place when the review interviews were completed.

equity and cultural safety for GP trainees e.g. Te Ahunga programme, MIHI501 course costs for educators – 93% % of operational component of the contract.

- Component 3: Māori and Pacific Health. Specific funding to support and mentor Māori and Pacific registrars – 2% of the operational component of the contract.
- Component 4: GPEP 2/3 and beyond – 6% of the operational component of the contract.

The College reports separately on each contract component. In principle, money cannot be shifted between the different components except by mutual agreement with MOH. Overspend in any of the contract components is covered by the College and underspend returned to MOH.

From a College perspective there is a lot that goes into balancing the components. If I overspend on component 3 the College has to pay that, and we have no funding ... (RNZCGP)

3.3. The contracting process

The GPEP contract is negotiated annually between Health Workforce New Zealand and RNZCGP. In the future the negotiation will be between Te Whatu Ora/HNZ and the College. There is no input from other Manatū Hauora directorates including primary care, the Māori and Pacific Directorates.

The College negotiate registrar salaries based on a funding envelope agreed with the Ministry.

4. Registrar selection of general practice as a vocation

Key messages

The flexibility and ability to train part-time is an important incentive for participation in GPEP.

Although base salaries may appear similar, the terms and conditions and the employment category effectively result in lower incomes for College employed GPEP 1 registrars than hospital-based registrars. In DHB settings registrars also have opportunities to bolster their incomes through overtime payments. This difference in income between general practice and hospital-based specialties is a key barrier to entering GPEP.

Perceptions of general practice in DHB settings, limited exposure to general practice during under-graduate and post-graduate DHB years and the ability to work as a GP without completing GPEP contribute to perceptions of general practice as a 'lesser' speciality that is less attractive than higher status professions.

Opportunities:

Employment conditions aligning GPEP registrars with the same terms and conditions as DHB employed registrars would remove a key barrier to GPEP participation.

Enhancing the profile of general practice through promotion, compulsory community runs and positive GP role models in under-graduate and post-graduate years would contribute to building a positive profile of general practice.

4.1. Entering GPEP

The following are the annual timelines for GPEP applications:

- Applications for intakes open in February – recently shifted from December to align with other speciality programmes
- The selection process may include an interview
- Selected applicants may also be interviewed by a regional Medical Educator
- Unsuccessful applicants are notified in June/July and successful applicants offered a place with their confirmation of acceptance of the offer by August. Those accepted may not take up the offer or may defer between August and the start of GPEP 1.

- Applicants are confirmed their placement regions in the August timeframe, with their practice placement confirmed later. Manatū Hauora receives budget confirmation in July.
- Manatū Hauora approves the contracted number of registrars.

Registrars reported confusion and frustration navigating the College website and application form. Although registrars are advised of their placement region they are not notified of the practice until close to the start of GPEP. Availability of practices to provide placements is fluid with teaching fellows leaving potentially eligible practices or practices becoming unavailable for other reasons. The timelines may contribute to feedback we received about the college administration support which was widely described as inadequate across the GPEP years.

The high turnover of admin staff makes it impossible to get answers to queries or support. (Survey data - Registrar)

Many people highlighted the importance of overseas trained doctors and their contribution to the sustainability of primary care in Aotearoa New Zealand. Some overseas doctors shared their frustration over the application process to GPEP. The hidden costs, confusion around eligibility based on visa status and expectation to be retrained deterred potential overseas doctors from entering GPEP.

Financial as a resident but not quite a permanent resident. I had to fund my own training and find my own job at considerable cost. No support to do this... I wanted to be a GP, desperate need in NZ for GPs but I had to pay 40k for the privilege. This would put off a lot of potential GPs from applying. (Survey data – Registrar)

Overseas trained doctors are often placed in rural areas. The implications are an increased need for cultural safety education and potential lack of continuity of care as overseas trained staff move on.

I know for example, in our local owned practice none of the medical staff are from here, they don't whakapapa here. In fact, many of them are international people that come here by way of being able to secure a job in a New Zealand lifestyle. I don't think that they're often here for the long haul. Many of them are here to kind of gain their visa residency and immigration stuff, and meet the clinical requirements, but then they move on. And they tend to move around the rural communities because there's just no one that's applying for those jobs. (Manatū Hauora Stakeholder)

4.2. Trends in registrar participation in GPEP

Trends in registrar participation were examined for registrars entering GPEP from 2015-2020. This time period was selected as providing an opportunity for the earliest cohorts to have completed training while also allowing feedback from registrars entering GPEP more recently.

Analysis of the cohort found:

- The number of new registrars per year fluctuates. The highest numbers were in 2016/17 intake.
- There has consistently been a higher proportion of female than male registrars.
- The median age is 30-32. A small proportion of older registrars reflects overseas trained doctors and some New Zealand trained general registrants entering GPEP.
- Registrars identifying as Asian ethnic groups are over-represented compared to their proportion in the population and Māori registrars are under-represented.
- There was no significant difference in post-graduate years on entry for registrars with NZ primary qualifications by ethnicity.

Table 2. Registrar profiles (Source: RNZCGP and MCNZ data)¹³

GPEP Intake Year	2015	2016	2017	2018	2019	2020
Total number of trainees in College data	184	241	234	186	170	216
Total contracted trainees (Manatū Hauora data)		171	183	190	193	184
Medical post-graduate years at entry (mean)	7.9	10.1	8	7.7	7.5	7.9
Medical post-graduate years at entry (median)	5.5	6	6	5	5	6
% Female	65%	61%	58%	54%	59%	57%
Median age (years)	30	32	30	30	30	31
% Māori	8%	7%	6%	8%	9%	9%
% Pacific	1%	5%	3%	5%	5%	6%
% Asian	36%	36%	32%	32%	28%	33%
% European/other	60%	60%	63%	60%	66%	58%
% Overseas trained	34%	32%	27%	32%	29%	36%

4.3. Reasons for selection of general practice as a vocation

The most highly rated reasons survey respondents gave for entering GPEP were the flexible hours and opportunity to train part-time (Figure 2). Registrars compared the long-rostered shifts in the hospital to the flexibility and work life balance of general practice. Flexibility and family-friendly hours were particularly attractive to registrars who had young families or wanted to start families.

No other speciality offers such flexibility from so early on as GP. I was a parent of three children. (Survey data - Registrar)

¹³ Assumptions: To deal with duplicates: we extracted the most recent time a person was recorded in the MCNZ register as well as in the GPEP admission list. This gave us 1,231 total trainees from 2015 to 2020. Demographic information was taken from the MCNZ register data. Ethnicity is based on total-count where people are included in each ethnic group they identify

Post-graduate years were calculated with the assumption that non-Australian/non-NZ IMGs graduated on 30 Jun and Australian IMGs graduated on 30 Dec. For NZ graduates, we used provisional date as a proxy as universities have inconsistent way of assigning primary qualification years.

However, a key implication of flexible and family-friendly hours is a lower income compared to DHB-employed registrars with the potential to supplement their base salaries with overtime hours.

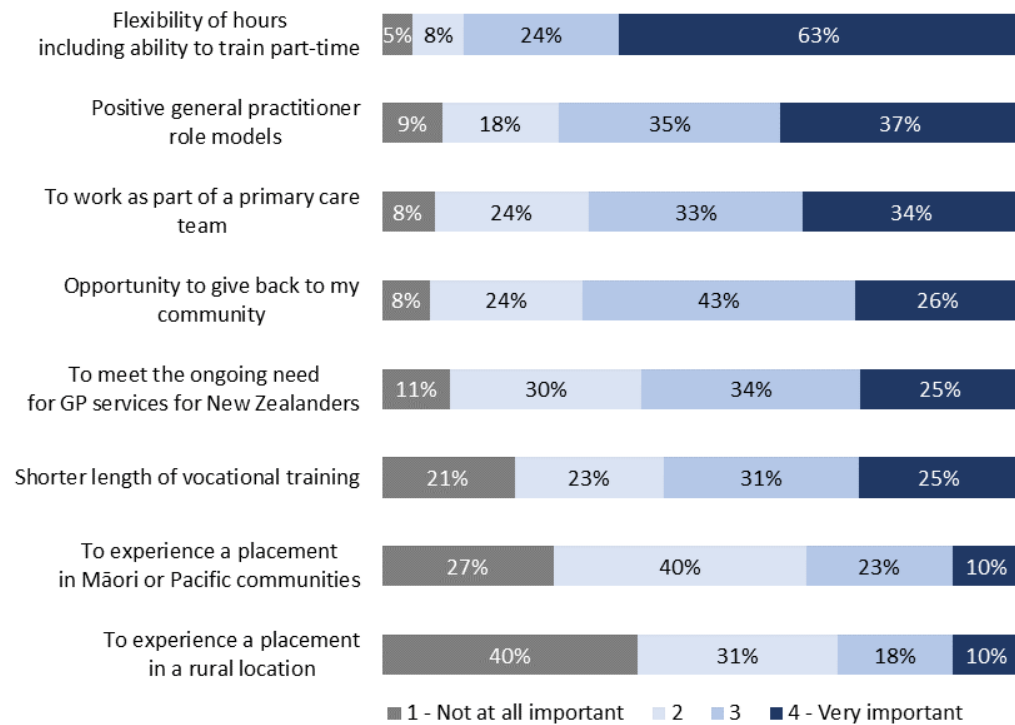


Figure 2. Current and past registrar survey – reasons for selecting GPEP. All statements were rated on a 1 (not at all important) to 4 (very important) scale (n=411-413).

Those who worked part-time considered flexible hours¹⁴ more of an incentive with means of 3.32 for full-time and 3.66 for part-time registrars¹⁵. Females were more likely than males to rate flexibility of hours highly¹⁶.

¹⁴ There was a statistically significant difference in mean positive general practice role models between full-time and part-time, with part-time registrars scoring 0.341 higher than full-time registrars (95% CI, 0.176 to 0.506), $t(359) = 4.069$, $p < 0.001$.

¹⁵ Other facilitators were not statistically significant between full-time and part-time registrars.

¹⁶ There was a statistically significant difference in mean flexibility of hours between males and females, with female registrars scoring 0.244 higher than full-time registrars (95% CI, 0.059 to 0.429), $t(212) = 2.594$, $p = 0.010$.

Registrars who worked full-time were significantly more likely to rate working as part of a primary care team¹⁷ and positive general practitioner role models¹⁸ as incentives to enter GPEP compared to those who worked part-time. Positive general practitioner roles were rated more highly by males than females¹⁹.

It was evident through interviews and survey analysis that the importance of primary care in the Aotearoa New Zealand health care system was also a reason for deciding to become a GP. Registrars gave examples of patients they had treated in the hospital system for whom treatment in general practice could have prevented the need for secondary care. The idea of supporting and treating patients rather than being *the ambulance at the bottom of the cliff* appealed to registrars who understood and valued general practice.

I saw so many patients in the hospital who could have avoided admission if they had been well engaged. (Survey data- Registrar)

Registrars committed to the value of primary care commonly described passion, enjoyment, ability to provide continuity of care to individuals and wider whānau, and the ability to implement and immerse themselves in the community as other contributing factors to choosing general practice. The ability to work in different locations was also mentioned by some registrars.

Although numbers were small, a higher proportion of Māori and Pacific doctors responding to the registrar survey rated the ongoing need for GP services and to experience placements in Māori and Pacific communities as important reasons to enter GPEP. Two Māori doctors specifically mentioned wanting to *escape hospital politics* and *leave the toxic hospital system*.

¹⁷ There was a statistically significant difference in means to work as part of a primary care team between full-time and part-time, with full-time registrars scoring 0.204 higher than part-time registrars (95% CI, 0.008 to 0.400), $t(336) = 2.044$, $p = 0.042$.

¹⁸ There was a statistically significant difference in mean positive general practice role models between full-time and part-time, with full-time registrars scoring 0.151 higher than part-time registrars (95% CI, 0.050 to 0.352), $t(332) = 1.478$, $p = 0.140$.

¹⁹ There was a statistically significant difference in mean positive general practice role models between males and females, with male registrars scoring 0.058 higher than female registrars (95% CI, 0.137 to 0.253), $t(273) = 0.584$, $p = 0.058$.

Table 3. Current and past registrar survey – reasons for selecting GPEP by ethnicity. The table summarises the percentage rating different statements as a 3 or 4 on a 1 (not at all important) to 4 (very important) scale.

	Pacific (n=12)	Māori (n=33)	Non-Māori, non-Pacific (=343-345)
Flexibility of hours including ability to train part-time	100%	88%	87%
Positive general practitioner role models	75%	76%	72%
Opportunity to give back to my community	92%	73%	67%
To work as part of a primary care team	75%	61%	69%
To meet the ongoing need for GP services for New Zealanders	75%	73%	58%
Shorter length of vocational training	67%	42%	57%
To experience a placement in a rural location	17%	27%	28%
To experience a placement in Māori or Pacific communities	75%	67%	29%

Although numbers were smaller, RMO survey respondents also rated flexibility of hours as the most important reasons for considering GPEP.

Table 4. RMO survey reasons to enter GPEP of those who did/are currently considering general practice as a vocational pathway (n=138) (3 and 4 ratings on a 1-4 scale).

	Current PGY1 or PGY2 (n=71)	Current PGY3+ (n=38)	Registrars not in GPEP (n=29)
Flexibility of hours including ability to train part-time	99%	97%	97%
Positive general practitioner role models	90%	95%	79%
Opportunity to give back to my community	76%	79%	72%
To work as part of a primary care team	83%	74%	69%
To meet the ongoing need for GP services for New Zealanders	85%	79%	62%
Shorter length of vocational training	63%	55%	59%
To experience a placement in a rural location	58%	66%	45%
To experience a placement in Māori or Pacific communities	62%	58%	41%

Some medical students entered medical school with aspirations to be a general practitioner. General practice was the first choice for vocational training for 71% of survey respondents. Others who entered GPEP 1 described being unsure of what speciality to pursue but acknowledged and attributed their general practice choice to the academic exposure to general practice and experience of the community-based attachments.

...I did the rural programme and the fifth year at Otago University, where we did a lot of general practice as part of the curriculum for that year, and quite enjoyed it (Interview - Registrar)

For those for whom general practice was not their first choice of vocational training, the most common first choices were anaesthetics, emergency medicine, paediatrics and rural hospital training. Common reasons for changing to general practice were in response to burn out, to have better working conditions and interest in general practice.

Almost completed Oncology training, but preferred flexibility offered by GP. Having worked in hospital training, GP is a poor cousin. Undervalued and under-resourced. (Survey data - Registrar)

Considered Gynaecology but felt training years and on call hours too long and did not enjoy obstetric emergencies so did not apply. (Survey data - Registrar)

Shifted to general practice as that aligned better with my evolving sense of self and values/ideals. (Survey data - Registrar)

I had always wanted to be a GP when in medical school but the focus in med school and in the post graduate years as a junior doctor are heavily slanted in favour of hospital medicine. I just forgot about general practice for seven years. (Survey data – Registrar)

After having children I discovered GP after meeting and working with some of the best GP's and smartest doctors I've ever met. This was life changing. (Survey data - Registrar)

Paediatrics. But I resigned due to horrendous working hours and night shifts. And I am very happy I did. Plenty of paediatrics in general practice. (Survey data - Registrar)

4.4. Barriers to selection of general practice as a vocation

Lack of pay parity and employment conditions with other vocational training programmes was widely described by registrars as a main barrier to selecting general practice. In the registrar survey and RMO surveys, salary in GPEP 1 was the most noted barrier to entering GPEP training (Figure 3; Table 5). Registrars explained

their financial commitments to a mortgage, childcare, schooling and other life costs could not be maintained on the current GPEP 1 salary.

A financially big hit compared to previous wages and also compared to house officer salaries. If my other half was not also working we would not have been able to afford to do training scheme and I would have worked in general practice as a non-fellow ongoing. (Survey data – Registrar)

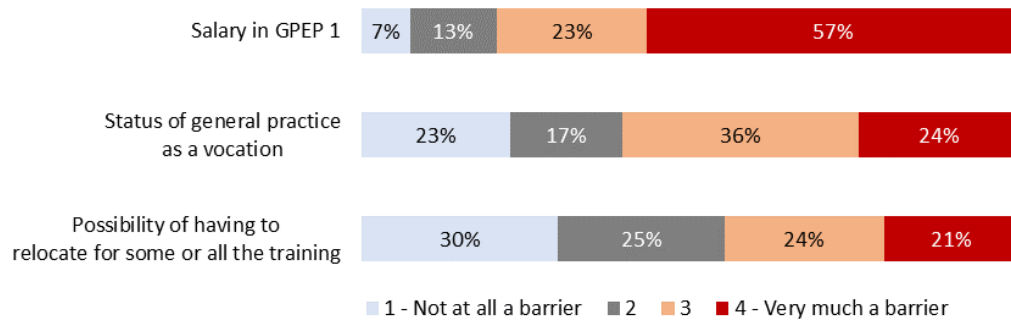


Figure 3. Current and past registrar survey GPEP barriers. All statements were rated on a 1 (not at all a barrier) to 4 (very much a barrier) scale (n=398-410).

There were no statistically significant differences in means between females and males in the extent salary in GPEP 1, status of general practice, and the possibility of having to relocate were barriers to entering GPEP.

The absence of protected learning time and funding associated with learning were also described in interviews as barriers.

Funding CME for GPs - we're required to do this for registration but carry all the costs (compared to DHB employees). (Survey data – Registrar)

The status of general practice as a vocation and the possibility of having to relocate were also barriers for RMO considering GPEP (Table 5).

Table 5. RMO survey barriers to GPEP of those who didn't/are not considering general practice as a vocational pathway (n=57-61) (3 and 4 ratings on a 1-4 scale).

	PGY1 or PGY2 (n=29-32)	PGY3+ (n=17)	Registrars not in GPEP (n=11-12)
Salary drop in GPEP 1	77%	88%	67%
Perceived lower status of general practice as a vocation	45%	76%	42%
Possibility of having to relocate for some or all of the training	63%	53%	45%

The perception of general practice as a second-class specialty was commonly noted as having a negative impact on registrars deciding to complete GPEP. Throughout in-depth interviews and in comments in the survey, participants discussed the

disconnect between primary and secondary care, with secondary colleagues often misunderstanding the role of a general practitioner. Some participants shared the public misconception of a GP as also being a barrier. Registrars often saw and heard about GP burnout in addition to the sector undervaluing general practice, which also contributed to them staying in the hospital system.

Several of those we interviewed highlighted that doctors can practice in a general practice without completing GPEP and without being a fellow of the College. There are no financial benefits such as different capitation fees or other benefits to being a fellow of the College. These factors contribute to the perception that general practice is a lesser speciality.

Within New Zealand society there is a real feeling of, they are a hospital specialist or they're just a GP. In everything that the College does now, we refer to them as specialist GPs because they have done specialist training which is what the GPEP training is. (RNZCGP)

Lack of known career pathways, promotion of work opportunities and the uncertainty of general practice in the near future were also described as barriers to entering GPEP.

While relocation is a component of other vocational training programmes, in GPEP the incentive of flexible training and the high representation of females makes relocation more of a challenge. In response to the survey, 46% of the 64 registrars who had to relocate for GPEP rated relocation as difficult or very difficult (Figure 4).

Registrars who were required to move away from their families, support systems and particularly those with young children described the lack of flexibility and consideration of suitable placements. Challenges with placements were described as the costs of moving and finding accommodation, and inability to plan because of late notification of practice placements by the College. Some registrars mentioned they were notified of their placement one month prior to commencement of GPEP 1.

Stakeholders considered the accommodation supplement²⁰ for rural placements was inadequate but that has recently been increased.

I was not in a position to travel for GPEP having a young family and a child with special needs. If I was not placed in my area I would have turned down the position. (Survey data - Registrar)

I had to borrow a large sum of money in order to relocate and support my family while training as a GPEP 1. The pay cut moving from ... to GPEP training (approx \$30,000+ over the course of GPEP 1) is a huge disincentive to doctors with a settled lifestyle and well-progressed careers in other specialties. (Survey data - Registrar)

²⁰ An increase in the accommodation allowance has been agreed for the next registrar cohort.

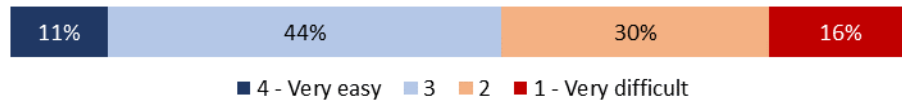


Figure 4. Current and past registrar survey ease of relocating in GPEP 1 on a scale from 1 (very difficult) to 4 (very easy) (n=64).

4.5. Opportunities

Registrars responding to the survey were asked for suggestions about opportunities to attract registrars into GPEP (Figure 5). Suggestions were provided by 288 registrars.

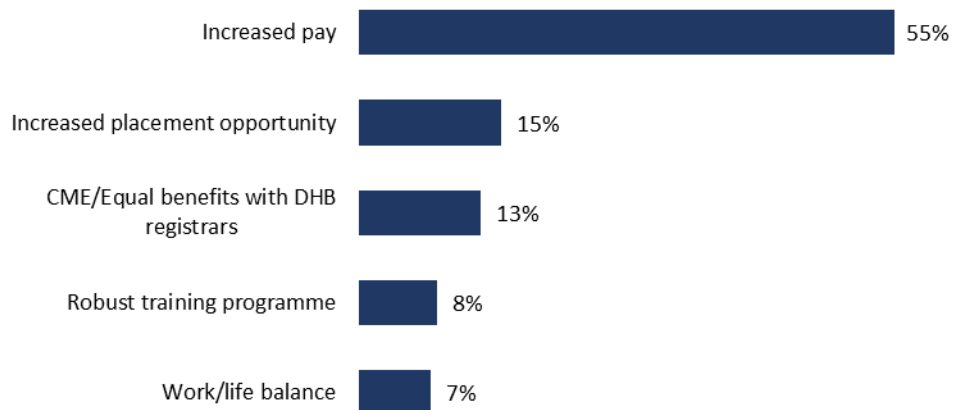


Figure 5. Opportunities to attract registrars to GPEP open text (n=288).

- The most frequently suggested opportunity (55% of comments) was to increase pay and achieve pay parity with other registrar programmes.
Competitive salaries, being seen as equals to our hospital-based colleagues and specialists in our own right (instead of 'cop out' koretake only work part-time GPs)
- 15% of registrars highlighted the importance of increased primary care placement opportunities particularly during medical school and house officer years. Survey responses recognised the value of general practice runs with some registrars attributing their GPEP entry to their experience during GP runs. Some registrar survey respondents also noted the importance of general practice runs as a mechanism to positively influence medical students perception of general practice.

I think that having house officer GP runs to get people to see both sides of care makes a big difference to change juniors opinion and understanding of GP barriers. (Survey data- Registrar)

- 13% of survey respondents noted the need to include continuing medical education and protected teaching and administration time into the GPEP contract. Some registrars commented on DHB benefits and suggested equal benefits as DHB registrars particularly pay-parity and CME at a minimum.
Have general practice paid equally to hospital doctors and give equal benefits e.g. leave/study benefits/work conditions/non clinical time and you will get more GPs. (Survey data – Registrar)
- 8% of survey respondents recommended providing a more robust training programme. Suggestions around a robust training programme included (but were not limited to):
 - Formal education in GPEP 2 and GPEP 3
 - Weekly teaching and seminars relevant to general practice
 - Opportunity for specific teaching (special interest/ subspeciality).
The GPEP 1 programme when I did it felt weak on lots of clinical stuff. It did not emphasise the fact that GPs are advanced generalists. - Actually have programmes for training GPSEs (GP's with special interests). Make it possible for trainees to nominate a special interest pathway from the outset. (Survey data – Registrar)
- Emphasising a career that enabled a work and life balance was noted by 7% of registrars as an opportunity to attract registrars.

4.6. Employment conditions for GPEP registrars – contract comparisons

A universal theme amongst those interviewed was the need for parity between GPEP registrars and DHB employed registrars in other vocational programmes.

Comparison of the base salaries and other terms and conditions of GPEP registrars found that the base salary for a 40 to 45 hour employment week was broadly similar to the early stages of the Resident Doctors Association MECA with DHBs, at the scale that applies for a 40-45 hour working week (Category F). However, most registrars employed with DHBs are placed at Category C or above, reflecting employment weeks of more than 55 hours. In effect this means that the majority of DHB registrars will have a base salary in the range \$15 to \$35,000 more than in GPEP 1. The extent to which the longer working week in the DHB setting includes time spent on education activities associated with the registrar role, and how this compares to unpaid educational time committed by GPEP registrars is unclear.

Beyond the base salary, the terms and conditions of the DHB MECA are more generous, both in terms of allowances, and in terms of leave entitlements. Moreover, the scope to earn increased income from additional duties, on call and overnight hours is significant in a DHB setting for most specialties.

Table 6. Employment conditions for GPEP registrars and registrars in other vocational training programmes

	GPEP 1 Agreement	NZRDA MECA ²¹
Less than 5 years post-grad - Base salary in urban areas	\$82,742	\$76,186 (Registrar Year 1) \$80,273 (Registrar Year 2) \$84,327 (Registrar Year 3) \$68,571 (Senior House Officer Year 3) \$72,242 (Senior House Officer Year 4)
Ordinary hours of work	40 to 45 hours per week, between 7.30am and 6pm, Monday to Friday	40 hours per week, no more than 8 per day between 7am and 5.30pm, Monday to Friday
Additional duty hourly rate		\$85 Registrar (0800-2200) \$130 Registrar (2200-0800) \$75 Senior House Officer (0800-2200) \$115 Senior House Officer (2200-0800)
Annual leave	20 days	30 days
Sick leave	15 days	30 days
Allowance for work undertaken in non-urban and/or high needs areas	\$3,000 per year maximum (\$1,500 for each 6-month attachment)	\$2,742 to \$3,375 (increment on urban base salaries)
Education-related expenses	\$2,600 per year for current practising certificate, medical indemnity insurance and required textbooks and/or equipment RNZCGP Associate Membership fees GPEP Year 1 written and clinical exam fees Annual membership of Te Ohu Rata o Aotearoa ACLS renewal fees to minimum m level 5 Either APLS or EMST, if relevant to the employee's attachment	Cost of annual practicing certificate Cost of membership of relevant post-graduate colleges \$300 per year maximum for membership of Te Ohu Rata o Aotearoa Cost of initial application for provisional general registration Actual and reasonable costs of the training undertaken to obtain a New Zealand or Australasian vocational scope of practice (include course, examination, modules and clinical assessments, other fees, required texts, travel, meals, accommodation)

²¹ Base salary for 40-44.9 hours of work in urban environment and standard (non-shift work) rosters, effective before 17 April 2022.

	<p>ACC PRIME courses for Rural Registrars attached to PRIME certified practices</p> <p>\$600 for the College's Annual Conference for General Practice</p> <p>\$590 for the annual Te Ohu Rata o Aotearoa Hui-ā-Tau and Scientific Conference and/or an approved alternate relevant conference</p>	<p>DHB shall provide professional indemnity insurance on a basis agreeable between the parties</p>
Relocation expenses	<p>\$3,000 per relocation to the Rural Practice area</p>	<p>\$750 transfer grant</p> <p>\$270 grant per child for school uniform</p> <p>\$2,332 refund for penalty mortgage repayment charges</p> <p>Expenses arising from buying or selling land (up to \$3,633)</p> <p>Expenses arising from selling the house within 2 years of the date of relocation (up to \$10,816 for aggregated legal and land agents expenses)</p> <p>Reasonable cost of the removal of furniture and essential effects to the new location</p> <p>Refund of up to one week's accommodation expenses for the employee and the family</p> <p>One week's accommodation expenses, followed by boarding allowance of \$45 per week, where an employee is required to maintain their family at the former location</p> <p>Employees without a family are offered accommodation in the DHB's staff quarters at the normal rates</p>
Travel expenses	<p>Motor vehicle mileage allowance, related to practice duties and/or travel to seminars and other training</p> <p>Travel expenses related to GPEP Year 1 examinations</p>	<p>Motor vehicle mileage allowance, where required to use own car for the purposes of work</p> <p>Cost of actual and reasonable fares for travelling to the new location at the beginning of the attachment, and return at the end of it (include the employee's family travel costs where the attachment is to be for more than 3 months)</p> <p>Cost of actual and reasonable fares for travelling to return to the base location for approved training courses, not more than once a month</p> <p>Meals and incidentals at \$65 per day</p>

5. Employment models

Key messages

Three-quarters (74%) of registrars were employed by the College for GPEP 1 in 2020. The College has advised this is trending downwards. College employed registrars are required to complete two six-month placements in general practices.

Motivation for being practice employed included higher salaries, and not being placed in a location or practice where registrars did not want to go.

Practice employed registrars generally stay in one practice for 12-months and depending on the practice may have limited exposure to a breadth of patients and contexts.

Many interviewed stakeholders and registrars felt there was a conflict of interest between the College roles of educator and employer.

Opportunities:

Separating registrar employment from the College's role as the educator has the potential to make it easier to place GPEP registrars on the same footing as other registrars.

Develop strategies to enable registrars to have a breadth of experience of different communities and general practices.

Standard employment contracts between registrars and practices would remove stress for GPE2/3 registrars and contribute to standardised employment conditions.

5.1. Employment in GPEP 1

Registrars who enter GPEP 1 have the option of three employment models.

- College employed
- Practice employed
- Self-funded

5.1.1. College employed

Information from the College identified College employment in GPEP 1 as the main employment option with 74% of registrars employed by the College in 2020²² (Table 7). More female than male registrars were employed by the College.

Table 7. Current and past registrar survey GPEP 1 employer (n=389). Survey responses were received from College and practice employed registrars.

Proportion of GPEP 1 employed by the RNZCGP	n of total	% of total	% of females College employed	% of males College employed	Another gender
RNZCGP data	159	74%	82%	62%	N/A
Survey data	329	85%	86%	82%	100%

Some registrars perceived a difference in support and chose to be College employed. Others did not understand the differences.

I went College employed because I was told you get better support going College employed and there is a higher pass rate of the exams because of that better support. (Registrar - interview)

College employed registrars are paid a salary from the College and have release time to attend the weekly medical educator workshops. Registrars who are College employed are required to complete two six-month runs with at least one of the runs in a high needs, Māori, Pacific and/or rural practice to ensure they are exposed to different types of practices and communities. During the application process, registrars who choose College employment indicate three preferred regions which will inform where the College places them. The College endeavours to place registrars in their top ranked regions. Some registrars noted negotiating with the College to complete College employed placements at one practice over 12 months.

5.1.2. Practice employed

Registrars employed by a practice were most likely to be employed by a GP owned and operated practice (Table 8).

²² The College has advised this is trending downwards.

Table 8. Current and past registrar survey GPEP 1 employer by practice type (n=407).

Practice type	RNZCGP employed		Practice employed	
	Count	Percentage	Count	Percentage
GP owned and operated	244	72%	39	58%
Part or wholly corporate ownership	56	16%	17	25%
Other third sector, trust, or community ownership	31	9%	10	15%
Iwi or kaupapa Māori general practice	18	5%	3	4%
Pacific organisation	6	2%	0	0%

There were mixed reasons why registrars decided to be practice employed. The College has no power to direct practice employed registrars to go to a rural practice. Practice employed registrars were employed over a 12-month period at the same practice. Some registrars did not want to relocate due to personal circumstances and saw practice employment as a way to remain in one practice.

While a 12-month placement had the advantage of removing the need for relocation, participants described the limitations of a twelve-month placement in their GPEP 1 year and lack of exposure and experience in different settings.

I was fortunate enough to work in two high needs places in Auckland and that is where I was put for College employed. I have friends who have walked into jobs in [practice location] and completed a year there and all they have had are the worried well. They haven't seen a huge range of things and haven't seen kids and it's more old people renewing their scripts, so they don't get as good experience. At the end of the day you still have a GP trainee coming out but I don't know if you necessarily have a well trained GP. (Registrar - interview)

Other registrars were attracted to practice employment by a higher nominal base income, although if employed as a contractor allowances for annual, sick and study leave may not be provided. If payment for a base salary of \$120,000 excludes the one day a week of education, then this will reduce base income to \$96,000. Other allowances may not be included, such as support for annual practicing certificates or other professional requirements. The perceived income of a higher hourly rate may end up being little different to, or even lower than, the College salary in net terms.

Practice employed registrars must negotiate their own contracts. We noticed in interviews that registrars, especially GPEP 1 registrars were not well prepared to negotiate contracts. They described the stress of negotiating contracts with little to no knowledge of what should be included. Registrars who accepted practice employed contracts generally carried the costs of traveling to the weekly medical education workshops, were not paid for the education days and may not be paid for holidays or sick leave.

Honestly, I don't think [practice employed] would suit most people. It was hard negotiating and there's so many things you have to take into account that people don't realize,. Your five grand exam fees - all these things they haven't even thought about. (Registrar - interview)

Some practices were committed to providing excellent teaching, learning and exposure to clinical work. Other practices took a hands-off approach and expected GPEP 1 registrars to integrate into the business model and generate profit.

A few interviewed registrars described feeling pressured to reflect their pay scale in the numbers of patients they saw. One registrar also noted the perception of practice employment as an opportunity for practices to earn money from having a registrar.

Even throughout the year, I had three or four times that [the practice manager] said, you're only just breaking even you'd better start increasing your patient numbers. (Registrar - interview)

On average across all practice types, those employed by RNZCGP saw 18 patients per day alone on their GPEP 1 placement. Practice employed registrars saw 21 patients. The numbers of patients seen by the 20 current GPEP 1 registrars (who completed the survey during their first placement for the year) was 11 for College employed and 17 for practice employed registrars.

In response to the survey booked appointment times in GPEP 1 were longer for current GPEP 1 registrars who at the time of completing the survey would be in their first placement (Figure 6).

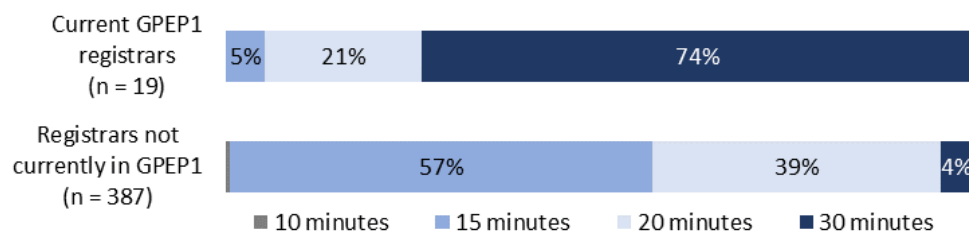


Figure 6. Current and past registrar survey standard booked appointment length in GPEP 1 by respondent GPEP stage.

When all survey respondents recalled the number of patients they saw per day in GPEP 1, the numbers were higher for practice employed registrars than College employed.

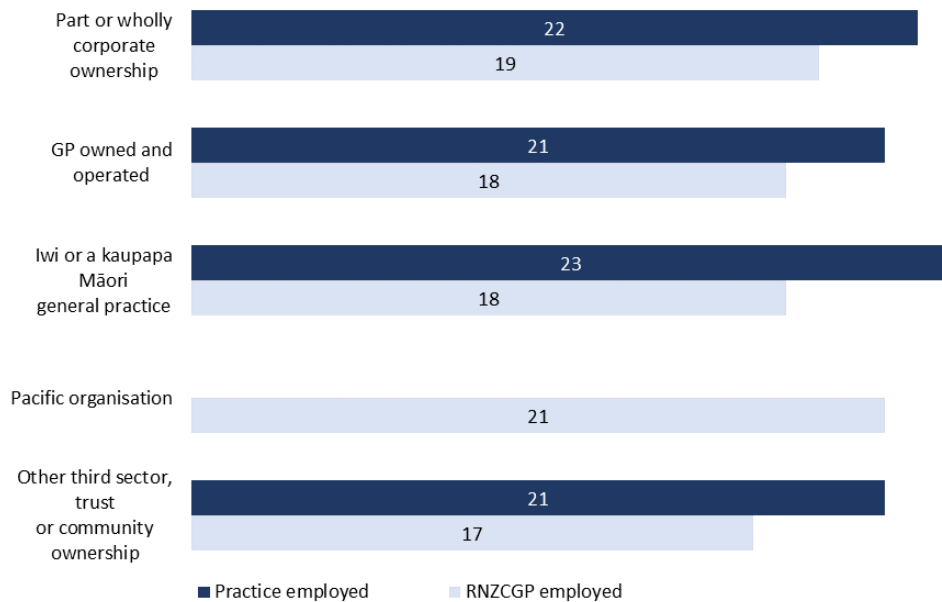


Figure 7. Average registrar-alone consultations per day in GPEP 1 placement by GPEP 1 employer and practice type (n=169) (no survey respondents were Pacific practice employed).

5.2. Employment in GPEP 2/3

In GPEP 2/3, registrars negotiate their own employment conditions, pay and benefits. Participants widely stressed the ‘*sink or swim*’ approach in GPEP 2/3. Many registrars particularly those who were College employed in their first year did not have experience of negotiations and business development and described feeling overwhelmed.

I do think there are challenges with the contracting model. I think it's a bit exploitative of GPs because practices get a fantastic deal. They pay us by the hour for the patients we see and they have no responsibility for us, no annual leave, no sick pay, no paying for teaching or medical learning. You are a free-lancing doctor, so you pay for everything yourself. We are suddenly thrown into running our own business which is something we haven't been trained in. (Registrar - interview)

5.3. Registrars in other programmes

Registrars in almost all other professional programmes are employed by their DHB. They are salaried employees and receive generous annual leave, and sick leave, and domestic violence leave required under New Zealand employment law. They also

receive paid study time, continued medical education allowances, and travel allowances. As salaried employees they do not have to negotiate their employment agreements.

There are a small number of exceptions to this broader comparison. One exception is Urgent Care registrars who are typically self-employed contractors in Urgent Care Clinics. However, some of their placements may be in DHB settings.

There are advantages in being self-employed. These usually relate to the potential to earn higher incomes, own a practice and practice buildings, and have autonomy over working hours. Under the current model of general practice many of these benefits are not realised, if practices do not generate substantial surplus, or if a contracting GP is not a practice owner.

6. Educational experiences

Key messages

The current GPEP funding model focuses education on the first year.

Registrar feedback about their educational experiences in GPEP 1 was positive. They generally had good support from their medical educator and in-practice teacher.

At the end of GPEP 1 most felt prepared for GPEP 2. However, most interviewed registrars and other stakeholders felt the educational/teaching component of GPEP 2 was inadequate. They wanted more frequent peer and mentor sessions focused on case reviews.

Many considered the clinical component of the exam at the end of GPEP 1 should be in the middle of GPEP 2.

Opportunities:

Expansion of teaching in GPEP 2 and moving the clinical exam to the middle of GPEP 2 would provide the additional education and support registrars and teachers identified as needed.

6.1. GPEP 1

The current GPEP funding model focuses education on the first year. During GPEP 1, registrars were supported by a teaching fellow in their placement practice, a facilitator medical educator and a lead medical educator.

6.2. Matching process

Matching with general practices for placements was an important part of preparation for GPEP 1. The College reported trying to match registrars with their top location preference on their application form. The College also reported prioritising placing Māori and Pacific registrars in Māori and Pacific practices.

However, matching was challenging for the College as the number of practices wanting registrars exceeded the number of registrars available, Māori and Pacific practices were not available in all areas, not all registrars accepted for GPEP entered the programme and the availability of accredited practices and teaching fellows could be fluid.

Our job at the college is to find them a home. We try and match a practice with a registrar. We ask their preferred location as in region, within the contract with the

Ministry they must do one high need or rural in their first year. That sounds simple but the complexity around placing registrars is enormous.... It is a giant jigsaw puzzle and it takes months to jiggle everyone around. It is in an environment where there is not enough supply of registrars. (RNZCGP)

Registrars who remained in College employment were matched to districts and placed in practices by the College, in consultation with the regional medical educator. Registrars could indicate their preferred community and region but ultimately the decision was at the discretion of the College. Registrars shared examples of 'match swapping' with other peers to get the practice, location and/or community they wanted. In one case, there were more than four registrars who connected and swapped placements, but this can only happen with College approval.

Literally in our group, there was three people who nearly pulled out of the GP training programme because they were given placements that would not work for their family. (Registrar – interview)

Registrars suggested meeting regionally to discuss practice availability, desired location and expectation. They suggested this approach would reduce the mismatching of registrars to practices and provide a balanced opportunity for medical educators and registrars to discuss and plan placements.

6.3. Experiences working in a general practice with a high proportion of Māori or Pacific patients

A placement in a general practice with a high proportion of Māori patients provided non-Māori and non-Pacific registrars with opportunities to learn about cultural safety, understand te ao Māori contexts and build confidence.

I think it is important that registrars are placed at Māori and Pacific health providers, I think that is the only way you are only going to get the experience. I did find the wānanga Te Ahunga orientation that we went on really useful and really enjoyable and we had a number of teaching sessions on Māori health which were useful. I think that should be absolutely part, but I think the only way registrars will have experience of Māori and Pacific health is if they work at those providers. (Registrar – interview)

6.4. Experiences of working as a registrar in rural general practices

Placements in practice in rural locations provided registrars with understandings of rural contexts and contributed to them wanting to practice in those locations in GPEP 2/3 or as a fellow of the college.

Being immersed in the community you can't help but create a bond or sense of responsibility and loyalty to that community where actually I would like to work here and I may not spend my whole life here but I would like to spend time here giving back because I feel connected and I belong to this community. (Registrar – interview)

6.5. Preparedness for GPEP 2

Surveyed registrars considered they were well prepared for patient-centred counselling and communication skills at the end of GPEP 1 (Table 9).

I don't think we had any teaching sessions whatsoever on record keeping. No one ever teaches you how to write notes that is a deficiency in medical school and specialty training. You are told you need to write notes and they need to be contemporaneous, but I don't think I have ever, ever in my medical education had a lecture or teaching sessions on how to write a note. (Registrar – interview)

They felt less prepared for consultation with Māori, Pacific patients and those in rural communities. Registrars generally felt less prepared for GPEP 2 than their teachers considered them to be.

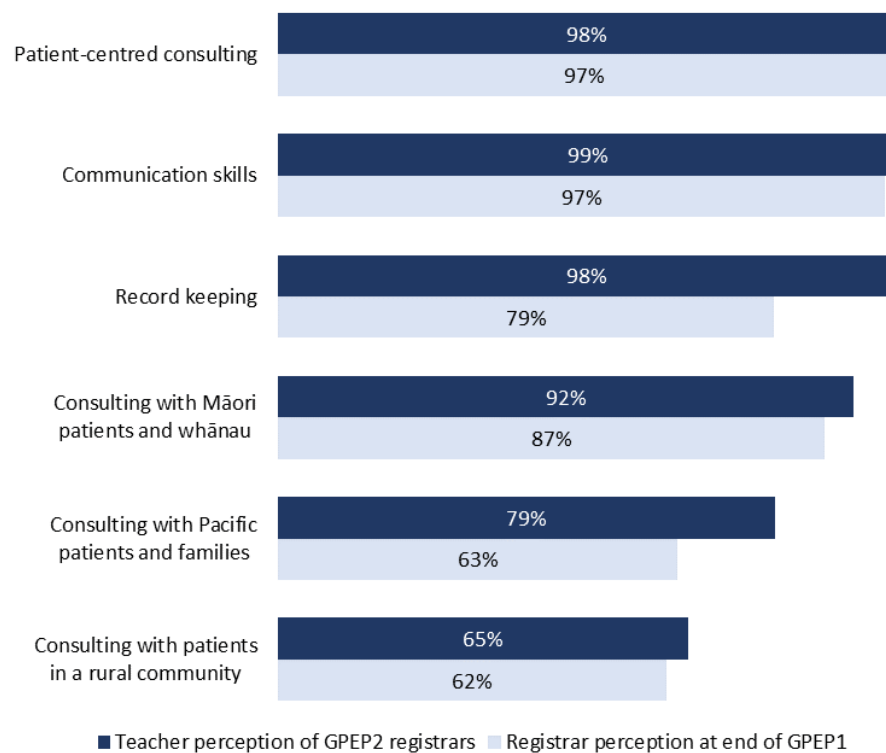


Figure 8. Teacher and registrar perceptions of registrar preparedness for GPEP 2, those who rated 3 and 4 on a scale from 1 (not at all) to 4 (very prepared). (Survey responses for registrars and teachers).

6.6. GPEP 2/3

The education programme for GPEP 2 and GPEP 3 registrars comprises in-practice mentoring and facilitated peer group meetings over the duration of the programme. A teaching fellow is not required to be in the practice when registrars entering GPEP 2 who have successfully achieved the clinical examination are practicing. There is no funding for practice-based teaching in GPEP 2/3.

When exploring the educational experience of GPEP2 and 3, registrars noted there was no major difference aside from the scattered teaching sessions throughout the year in GPEP 2. Many described GPEP as essentially a one-year programme.

...turn GPEP 2 and GPEP 3 into proper training years - as they currently stand there is no practical difference between those years and fellow years. In practicality GP training is only one year and this is a disincentive - at least it was for me. (Survey data – Registrar)

While most registrars and other stakeholders considered GPEP funding enabled a robust training programme for GPEP 1 it did not provide adequate support for GPEP 2/3. They described the support as almost non-existent and particularly dangerous for registrars who needed additional learning and training to pass exams. Registrars in hospital settings entering their second year of speciality training were described by stakeholders as being more closely monitored than GPEP 2 registrars.

GPEP 1 registrars were required to sit the clinical and written exams (summative assessments) at the end of their first year. A pass in their clinical examination is necessary for registrars to enter GPEP 2 without requiring a teaching fellow to be onsite. Many of the interviewed teachers and medical educators acknowledged that there are a cohort of registrars who do not pass the exams and continue to progress towards GPEP 2.

We set some people up to fail because we send them into the exam knowing that they are not ready yet, but we don't have an opportunity to support them into their second year. (RNZCGP)

The College described providing identified 'at risk' registrars in GPEP 2/3 with additional support that includes remote learning groups in addition to normal teaching sessions. This additional support was not funded in the 2020 Manatū Hauora contract, and so this College initiative runs on a '*shoe string budget*' and was not considered as adequate by the interviewed stakeholders. The 2022 contract has provided additional funding to support these registrars.

...GPEP 2 there is less [teaching]. The [teachers] don't get paid teaching time the contract pulls right back and the amount of money that goes to year 2-3 and beyond is next to nothing. (RNZCGP)

GPEP 2 registrars did not feel the support they received adequately reflected the fee payments that were required. This often led to GPEP 2/3 registrars feeling resentful, devalued, and let down by the college due to funding constraints.

Participants were particularly passionate about repositioning the exam dates. Some felt the written exam could remain in GPEP 1 and the clinical exam be moved to an optional date between GPEP 1 and halfway through GPEP 2. This would allow extra clinical practice for registrars.

6.7. Clinical preparedness to practice

Surveyed registrars were asked to rate on a four-point scale the confidence they had gained for their current stage of training in clinical experience and cultural training (Figure 9). Confidence in clinical experience was generally higher than in cultural competence.

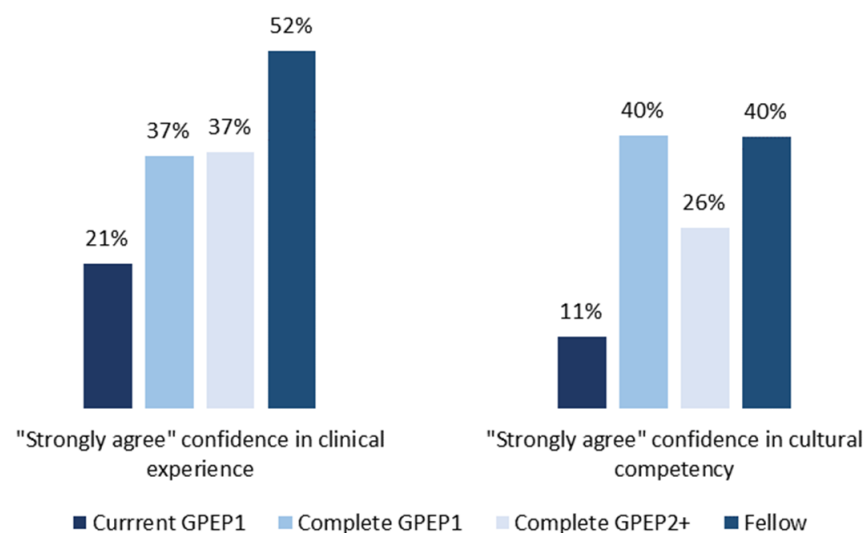


Figure 9. Current and past registrar survey confidence at current stage of training, those who rated 4 on a scale from 1 (strongly disagree) to 4 (strongly agree) (n=372).

Some teachers and practices described providing additional support for some GPEP 2 registrars who were not competent. Additional support included a weekly catch-up with GPEP 2 registrars to ensure they were confident and competent to practice alone. This additional time was paid through the practice budget.

I am still meeting weekly with the GPEP 2 and we are paying for that as a practice to try and make sure he gets off to a good start (Teacher)

Registrars employed by DHBs in other professional programmes may have more options about changing to other programmes or returning to general DHB

employment. One stakeholder explained it could be difficult for GPEP registrars to return to DHB employment.

6.8. Health and safety

Registrars were asked in the survey to rate their wellbeing across the four domains of Te Whare Tapa Whā. GPEP 1 registrars rated their taha wairua and taha whānau more highly than their taha tinana or taha hinengaro (Figure 10). Two current GPEP 1 registrars gave the lowest rating to their taha hinengaro.

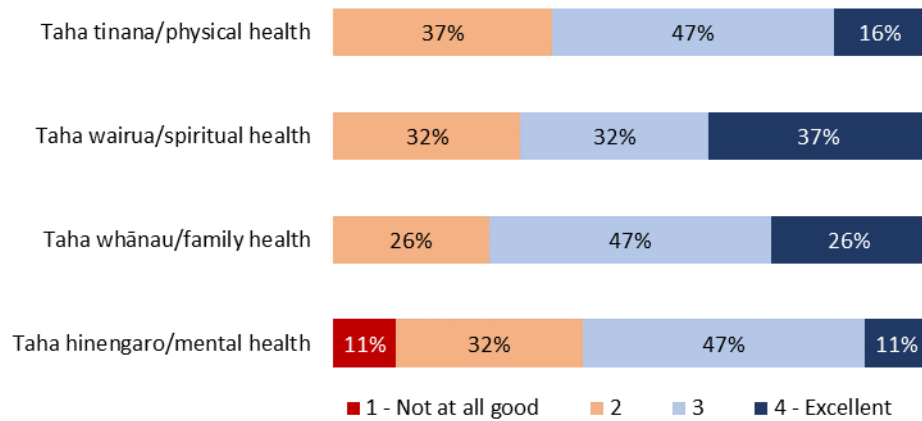


Figure 10. Current and past registrar survey current GPEP 1 registrar wellbeing rating on Te Whare Tapa Whā on a scale from 1 (not at all good) to 4 (excellent) (n=19).

GPEP 2 survey respondents rated all four domains of wellbeing more highly than GPEP 1 respondents.

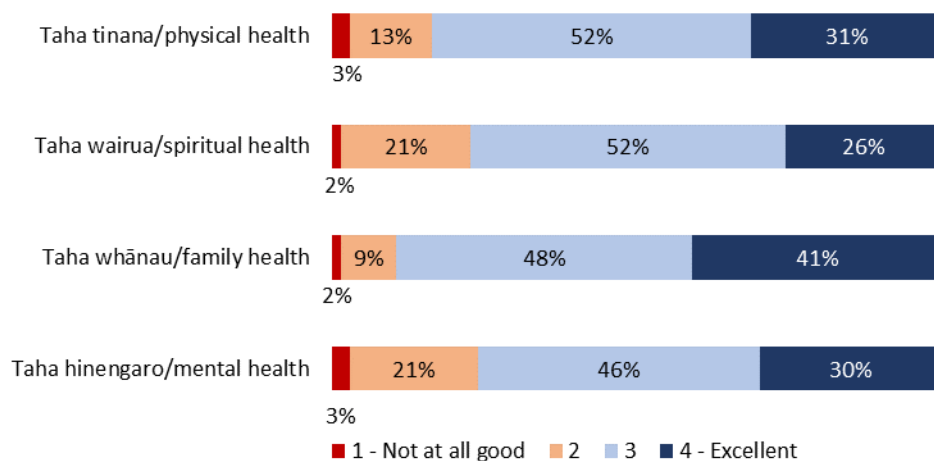


Figure 11. Current and past registrar survey current GPEP 2 registrar wellbeing rating on Te Whare Tapa Whā (n=66-67).

Health and safety and the employer’s responsibilities in GPEP 1 were discussed with registrars and other stakeholders. A frequent theme was of conflict between the health and safety responsibilities of the College as an employer and the College’s role of educator.

The College is the core knowledge of the discipline so it’s appropriate they are the trainer but I don’t think the employer. Some potential conflict like quality assurance requirements. If you are the holder of the standard for cornerstone and you make that a requirement for teaching that would be considered a conflict of interest everywhere else because you are gatewaying your own systems. (Organisation stakeholder)

6.9. Trends in GPEP completion

Although GPEP is a three-year programme, the minimum completion time to achieving fellowship of the College is 42 months and the mean time is 48 months. The percentage completing in 2015 was 71%. In out years, many will still be completing. Covid related delays have pushed out completion times for some.

Table 9. Completion rates for the 2015 cohort (College and MCNZ data)

GPEP Intake Year	2015	2016	2017	2018	2019	2020
Total number of new trainees in College data	184	241	234	186	170	216
Trainees completed ²³ (Fellowship registered)	130	121	48	1	-	-
Percentage completing ²⁴	71%	50%	21%			

Registrars can put their training on hold and can take up to seven years (including GPEP 1) to complete the programme. Common reasons for putting GPEP on hold include maternity leave, doing another fellowship such as Rural Hospital Medicine, and some who need time out for wellbeing issues.

GPEP 2 is exhausting and demanding. (Registrar - survey)

I want my work to be part of my life and not my whole life. (Registrar - survey)

I have two friends who have left GP in their second-year registrar and one of them has gone back to ED to be an ED doctor and one has gone to general medicine and one of the things that they both found was the lack of support and on-going education in second and third year. (Registrar - interview)

²³ Registration and Annual Practising Record data from Medical Council of New Zealand 2008 - 2022

²⁴ As at March 2022

In terms of the college, I got 12 months off maternity leave and I got a letter from the college to say I can resume my training [12 months later]. I was hapū again with my third and so I applied for an extension of that leave. I would have had two toddlers and a new-born around the time where I was expected to study and sit exams and I wasn't going to do that. That is when I was basically told [by the College] there is nothing they can do about it and I had to formally withdraw from the College. ... (Registrar - interview)

I was asked to resign my position by the RNZCGP the first time I was accepted as I informed them I was pregnant at my interview. Due to the funding structure the Ministry would have withdrawn funding for my placement due to my pregnancy... (Survey data – Registrar)

7. Accredited practices and GP teachers

Key messages

Lead medical educators have an important role in education and pastoral care. Although they considered their workload exceeded the financial gain, medical educators said they generally undertook their roles because of their passion for general practice, primary care and community health.

Registrars responding to the survey were generally positive about the support they received from their medical educators.

Most GPEP 1 registrars felt well supported by their teaching fellows through mentorship, clinical supervision, corridor conversations and general support.

In response to the survey, teachers rated their main motivators to becoming a GPEP 1 teacher as contributing to a sustainable general practice workforce and providing training opportunities to support communities.

Sustainability to general practice, providing training opportunities were the most important motivators for practices becoming accredited. The main barriers to being an accredited practice were meeting the requirements to become a placement provider, the cost of providing placements and capacity for supervision.

Practices with low co-payments are likely to find a registrar financially costly in many circumstances.

Opportunities:

Only 21% of Māori practices are accredited and in localities such as Northland, Tairāwhiti, Taranaki, Bay of Plenty/Lakes and Whanganui/MidCentral there are no accredited Māori practices. Exploring ways to enable these practices to provide registrar placements has the potential to improve equity.

7.1. Medical educators

Medical educators are experienced GPs who are fellows of the College. There are two types of medical educators - lead and facilitating medical educators. Facilitating medical educators provide input and delivery of educational workshops. There is one Māori lead medical educator and six Māori facilitating medical educators. The GPEP Chief Examiner-Clinical is Māori, as is one of the two clinical leads employed by the College.

Lead medical educators provide educational support, pastoral care and address any associated issues and queries from registrars, teachers, and practices. Lead medical educators are required to provide some oversight for the delivery of the curriculum, work with College staff to facilitate guest speakers and presenters, and help facilitate the placement of registrars to practices. Medical educators are primarily responsible for running weekly seminar training days, and provide ongoing pastoral care to GPEP 1 registrars. Medical educators receive additional funded time to complete practice visits to assess registrars' progress and teaching quality.

That is another big part of the role and people do that to various levels. We support the practices, the teachers and the practice managers to get new teachers on board, getting new practices to host a registrar. Needing to know what is going on in the whole region regarding workforce, practice struggles and difficulties. You are constantly connected in because you don't want to have your registrars struggling. (Medical Educator)

Medical educators commonly noted the financial penalties they experienced in accepting the role. They considered their workloads were not adequately reflected in their pay. Although their workload exceeded the financial gain, medical educators said they generally undertook their roles because of their passion for general practice, primary care and community health. Positive experiences, role models and robust support during general practice journeys also contributed to GPs being medical educators.

I wanted to be a teacher before I became a doctor, but I love medicine and general practice so I was wanting to do what I could to encourage others to do general practice. I wanted to give back, a lot of people supported me as I went through my journey. (Medical Educator)

Registrars responding to the survey were generally positive about the support they received from their medical educators (Figure 12).

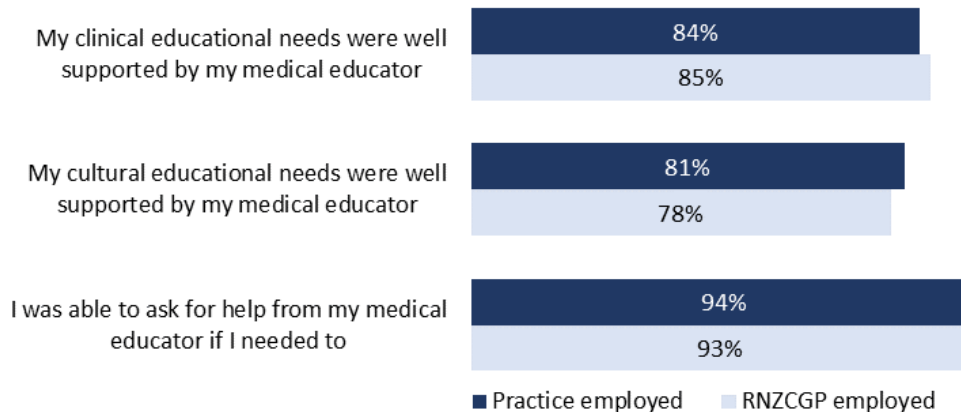


Figure 12. Current and past registrar perceptions of medical educator support in GPEP 1 by employer. Those who rated 3 and 4 on a scale from 1 (strongly disagree) to 4 (strongly agree) (n=408-409).

7.1.1. Medical education workshops

Participants were generally positive about the medical education workshops. Some participants discussed the need to provide a local approach particularly for registrars in rural settings and high needs practices.

The weekly medical education workshops were time-consuming and required a lot of travel for registrars in rural and remote communities. Some medical educators travelled to provide sessions in regional localities. However, the challenges of registrar travel had to be balanced against the advantages of opportunities to know their peers and to debrief with peers who understood their journey. Debriefing and reflective practice was particularly important for rurally isolated registrars.

GPEP 1 I think we have worked really hard to make that wrap around. We are aware that many of our new registrars are transitioning from only ever working in a hospital. We worked hard to put a good wrap around service in the practices in their learning and their learning groups. (Medical Educator)

7.2. Teaching fellows

Requirements to be a GPEP teacher are to:

- be a Fellow of the College
- hold a current practicing certificate from MCNZ
- practice for at least two tenths a week
- work within a teaching practice
- participate in Continuing Professional Development.

The teachers must be always on-site to provide support for registrars. Some teachers, generally teachers who worked part-time, described a shared role with other fellows in the practice. Some teachers who split the role recognised the expertise within the practice and felt registrars would benefit from having exposure to different skill sets.

Teachers were expected to provide weekly supervision of 1.5 hours. Registrars and teachers generally agreed on a suitable model. Some registrars completed the supervision on one day, others caught up in smaller intervals across the week.

Teachers noted the registrars required intensive support on their first run and that there is considerable variation between individuals. Teachers described the type of support they provided as including (but not limited to):

- checking notes
- observing consults
- debrief sessions
- day-to-day pastoral care
- informal corridor discussions and answering questions.

So my in house support was case based discussions on a daily basis and an hour and a half of teaching a week. And we had sometimes discussed pastoral staff if I needed it. (Registrar)

Teachers commonly stressed the actual time spent supporting registrars on a weekly basis completely exceeded the funded FTE from the College. Many teachers spent lunch breaks and worked after-hours supporting registrars in their practice.

We can only block 15 minutes out per session so I work through my lunch time. In the first three to six months I am spending an hour at lunch time and an hour at the end of the day plus the interruptions to pop out to see an ear or rash so you are doing two hours plus a day checking things and there is no way we could take me off the floor for two hours with what the college pays. They are essentially paying you for 15 to 30 minutes. (Teacher)

7.2.1. Registrar satisfaction

Most registrars felt well supported by their teaching fellows through mentorship, clinical supervision, corridor conversations and general support (Figure 13).

Many interviewed registrars described a good relationship with their teacher and of feeling valued in the practice. Though the expectations of providing a placement were clearly stated, some registrars shared examples of covering GP teacher caseloads, and practicing while fellows were off site.

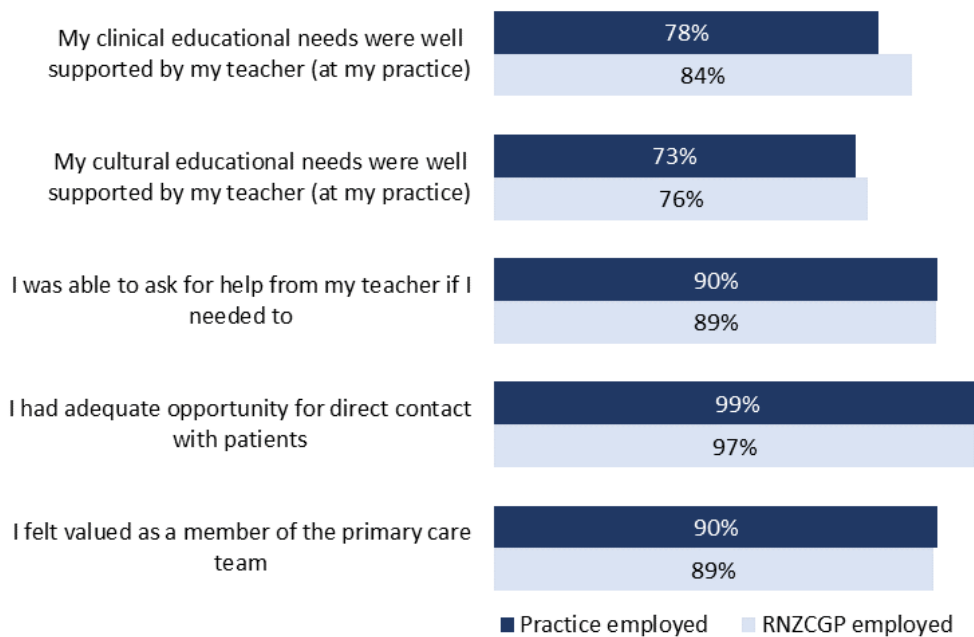


Figure 13. Current and past registrar survey - perceptions of practice support in their last GPEP 1 placement by employer. Those who rated 3 and 4 on a scale from 1 (strongly disagree) to 4 (strongly agree) (n=406-407).

7.2.2. Profile of accredited teachers

There were 557 teachers listed in the data provided by the College. Compared to the populations they support, there were differences in the demographic profiles of GPEP teachers (Table 10):

- Higher proportions are male (58%)
- Most teachers are European (75%) or Asian (16%) with very few Māori or Pacific teachers
- Teachers tended to be in the older age groups with 69% aged over 50 years.

Table 10. RNZCGP data profile of accredited teachers (n=383-579).

		n	%
Gender (n=557)	Male	323	58%
	Female	234	42%
Ethnicity (n=579)	European	432	75%
	Asian	91	16%
	Pacific	12	2%
	Māori	26	4%
	Other	26	4%
Age (n=557)	20-34	6	1%
	35-49	169	30%
	50-64	298	54%
	65-79	84	15%
Demographic (n=383)	Rural	90	23%
	Urban	262	68%
	Regional	31	8%
Location (n=385)	Northland	16	4%
	Waitematā	38	10%
	Central Auckland	50	13%
	South Auckland	27	7%
	Bay of Plenty/Lakes	39	10%
	Tairāwhiti	8	2%
	Hawke's Bay	14	4%
	Waikato	35	9%
	Taranaki	12	3%
	Whanganui/MidCentral	15	4%
	Capital & Coast/Hutt & Wairarapa	40	10%
	Nelson Marlborough	17	4%
	Canterbury/South Canterbury	43	11%
	Southern	31	8%

7.2.3. Reasons for becoming a teacher

In response to the survey, teachers rated statements about reasons for becoming a GEPP 1 teacher. The highest proportion of positive ratings were to contribute to a sustainable general practice workforce and provide training opportunities to support communities (Figure 14).

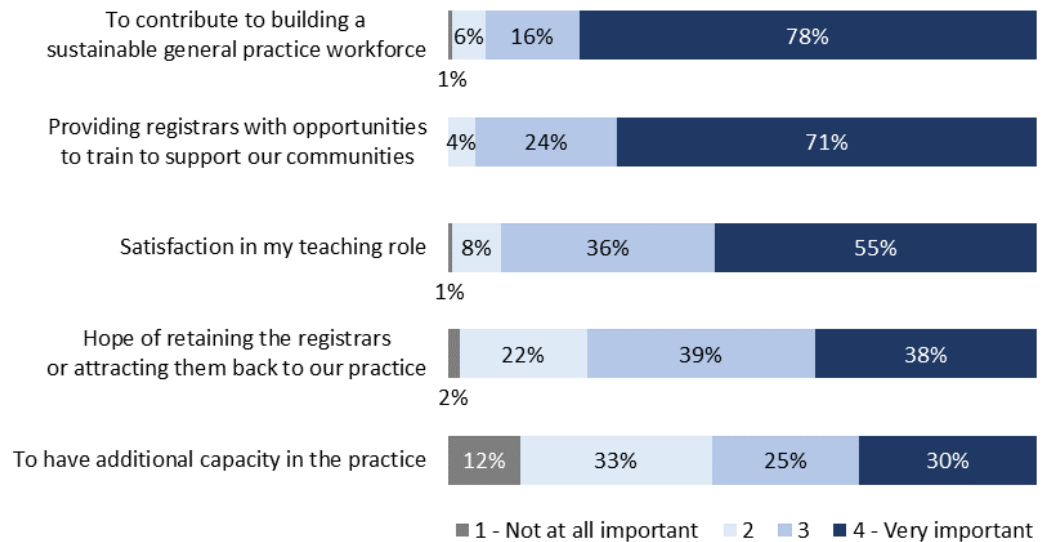


Figure 14. Teacher survey - reasons to being a GPEP 1 teacher. Each statement was rated on a scale from 1 (not at all important) to 4 (very important) (n=157).

GPEP teachers were often passionate about teaching, the workforce and sustainability of general practice. They described a sense of responsibility to give back to general practice by providing registrars with positive experiences of general practice and teaching.

We must provide pathways for training for the future workforce and we all need to contribute. (Māori Teacher - survey)

Some teachers were particularly interested in the survival of their practice and sustainability of workforce. The desire to have additional capacity in the practice was an important motivator for 30%. It was significantly more of a motivator for male GPEP teachers compared to females²⁵, with the mean response for males 2.89, compared to 2.52 for females. Males (44%) are more likely to be practice owners than females (26%)²⁶.

²⁵ There was a statistically significant difference in mean desire to have additional capacity in the practice between males and females, with males scoring .37 higher than females (95% CI .042 to .697), $t(150) = 2.23, p = .027$.

²⁶ <https://www.rnzcgp.org.nz/gpdocs/New-website/Publications/GP-Workforce/RNZCGP-2020-Workforce-Survey-Results-2-overview.pdf>

It is solely succession planning. It is really difficult to get doctors so I started teaching as a marketing exercise because I wanted someone to sell my practice to. (Teacher)

Many teachers spoke about the joy in having young and fresh registrars in the practice. This energy was welcomed by practices and often offered an opportunity for mutual learning between registrars and teachers. Teaching also provided a chance for isolated GPs to network with other GPs.

That dedicated teaching time is really good for the teachers' personal skill development because they are doing role plays and going over the latest techniques. Because the younger doctors are much more recently trained... they have access to all of the new teaching so its really beneficial both ways. I can't recommend it enough, the dual [benefit]. (Practice Manager)

Some teachers described the impact of a good role model which had influenced them to become teachers and contribute to strengthening the workforce.

7.2.4. Barriers to teaching

Inadequate payment to be a teacher was often cited as a barrier to becoming a teacher (Figure 15). Generally, teachers did not feel the teaching payments reflected the time, energy and effort they put in to supporting registrars. Some teachers reported not being paid at all and shared frustration around the practice receiving their teaching payments.

No, I don't think so. Because we haven't been paid for this year's GPEP I can't say how we are getting this year. My understanding for previous ones it was about \$700 a month for which I'm blocking out six appointments a day and each of those appointments we would cost at about \$70 then there is no way we are making ends meet. (Teacher)

Teachers commonly noted the increase in their workloads and limited capacity to provide a teaching experience for registrars as barriers to teaching. Some who had been teachers also noted they did not have the physical space within the practice to host a registrar therefore they did not gain the required practice accreditation.

Lack of confidence in teaching clinical skills was significantly more of a barrier for female GPEP teachers compared to males²⁷, with the mean response for females 1.96, compared to 1.71 for males. Some asked for more induction, support and guidance from the College. Some teachers and accredited practices noted disjointed communication with College administrative staff. Many participants highlighted the need to have staff who understood the primary care setting.

²⁷ There was a statistically significant difference in mean confidence in clinical skills as a barrier between females and males, with females scoring .249 higher than males (95% CI, .019 to .509), $t(3126) = 1.842$, $p = .068$.

*I don't really know anyone at the College at all. The titles are all non-clinical roles and they keep changing. I don't even know who is technically in charge of me.
(Teacher)*

Other barriers to teaching included lack of a guarantee of a registrar placement and that six-month rotations limited continuity of care for patients.

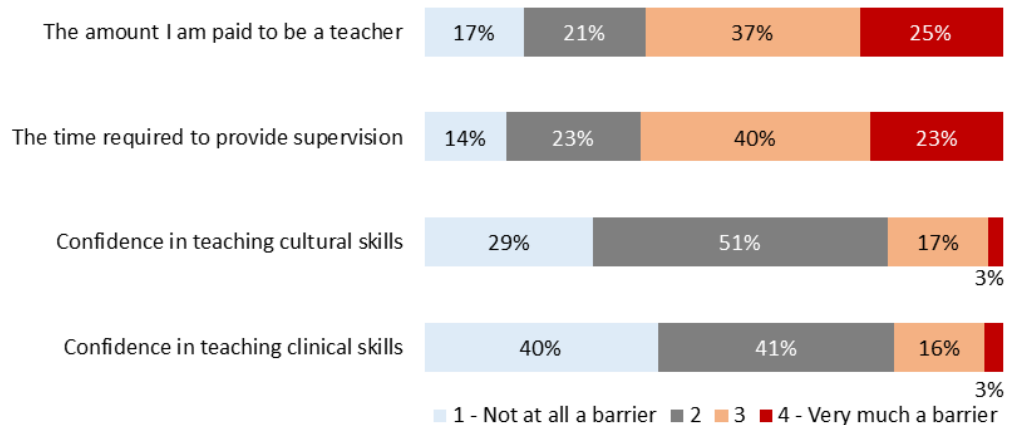


Figure 15. Teacher survey - barriers to becoming a teacher. Each statement was rated on a scale from 1 (not at all a barrier) to 4 (very much a barrier) (n=157).

7.2.5. Teacher wellbeing

Teacher wellbeing was generally positive (Figure 16). However, taha hinengaro was rated less positively than other domains of wellbeing.

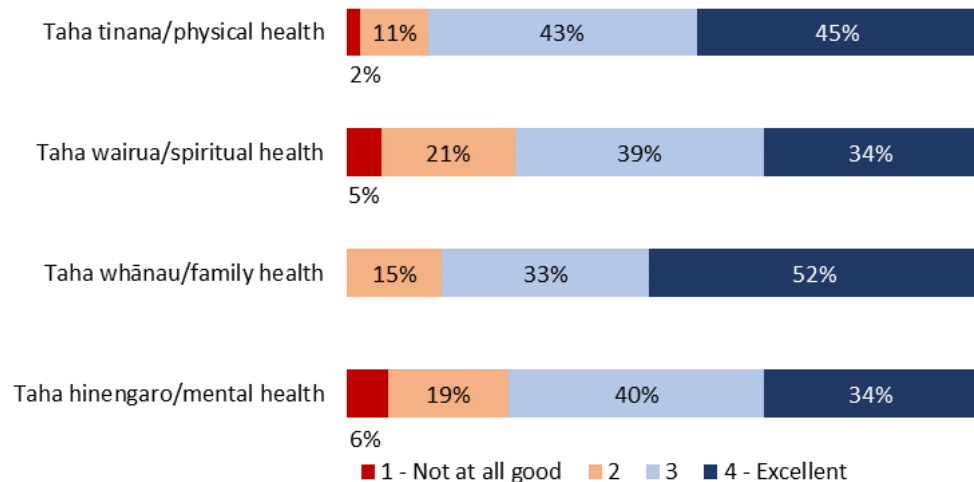


Figure 16. Teacher survey current GPEP teacher wellbeing on Te Whare Tapa Whā on a scale from 1 (not at all good) to 4 (excellent) (n=94).

7.3. Accredited practices

Practices who provide GPEP 1 registrar placements are required to always have an accredited teacher on site. This structure ensured the registrar had adequate support and resource from an allocated teacher.

Practices are also required to meet quality standards. Cornerstone accreditation was used as a mechanism to ensure quality. Cornerstone requirements are set at the minimum level and align with requirements to receive capitation funding.

The College is not only the educator but we set the quality standard for general practice. You have to have this standard to be a teaching practice. It's about making sure any registrar going in there is taught best practice and is not going to be put at harm. (RNZCGP)

7.3.1. Profile of accredited practices

There are accredited teaching practices in all DHB districts. However, the proportion of practices in districts that are accredited varies (Table 11).

The lowest proportions of general practices with accreditation to be placement providers were in MidCentral/Whanganui, the West Coast, Taranaki and Auckland/Counties Manukau.

Across the country, sixty-seven general practices (7%) can be defined as Māori based on a te ao Māori kaupapa and Māori governance. The same proportion of all accredited practices are Māori (7%). However, only 21% of Māori practices are accredited and in localities such as Northland, Tairāwhiti, Taranaki, Bay of Plenty/Lakes and Whanganui/MidCentral there are no accredited Māori practices²⁸.

In response to the survey one Māori doctor noted a lack of opportunities for placements with Māori and Pacific providers and another noted that those opportunities that were available were not well advertised.

There is already a demand [to go to a Māori or Pacific provider]. Not all registrars with a desire to work with Māori and Pacific organisations are afforded that opportunity now. (Registrar - survey)

Advertise Māori and PI roles better. There currently is minimal. I didn't understand what a Māori health provider actually does until I experienced it myself but would be nice to have experiences shared. I would highly recommend Māori NGO for Māori docs. (Registrar – survey)

²⁸ Information was not available to us about the proportions of Pacific practices that are accredited by the College

Table 11. Breakdown of RNZCGP data accredited practices from Manatū Hauora data and College data. Note different definitions of Māori practice may be used in identifying Māori practices (Manatū Hauora data – defined as a te ao Māori kaupapa and Māori governance) and the number of Māori accredited practice (College data).

DHB	Total # general practices (Manatū Hauora data)	# of accredited practices in 2022 (College data)	% of all practices that are accredited	# of all practices defined as Māori (Manatū Hauora data)	# of Māori accredited practices (college definition)	% of all accredited practices that are Māori	% of all accredited practices defined as rural	% of all accredited practices defined as high needs
Northland	36	8	22%	6	0	-	63%	88%
Waitematā	52	16	31%	0	0	-	13%	38%
Auckland/ Counties Manukau	291	44	15%	14	7	16%	2%	66%
Bay of Plenty/Lakes	60	10	17%	10	0	-	10%	80%
Tairāwhiti	11	3	27%	7	0	-	-	100%
Hawke's Bay	25	7	28%	1	1	14%	14%	86%
Waikato	74	17	23%	9	2	12%	18%	65%
Taranaki	29	4	14%	3	0	-	25%	50%
Whanganui/MidCentral	45	4	9%	4	0	-	-	75%
Capital and Coast/Hutt & Wairarapa	87	20	23%	9	3	15%	-	50%
Nelson Marlborough	30	10	33%	0	0	-	30%	50%
Canterbury/South Canterbury	137	28	20%	1	0	-	21%	32%
West Coast	7	1	14%	0	0	-	-	100%
Southern	81	15	19%	3	1	7%	47%	27%
Total	965	187	19%	67	14	7%	16%	56%

7.3.2. Reasons for becoming an accredited practice

Sustainability to general practice, providing training opportunities were the most important motivators for practices becoming accredited. Accredited practices also noted the importance of attracting registrars back and providing additional capacity in the practice (Figure 17). Some had become accredited to ensure they could replace exiting GPs with new registrars.

One of the motivating things is we have had three of our current GPs who have done their training with us who we have gone on to employ. That is a big motivator. (Accredited practice)

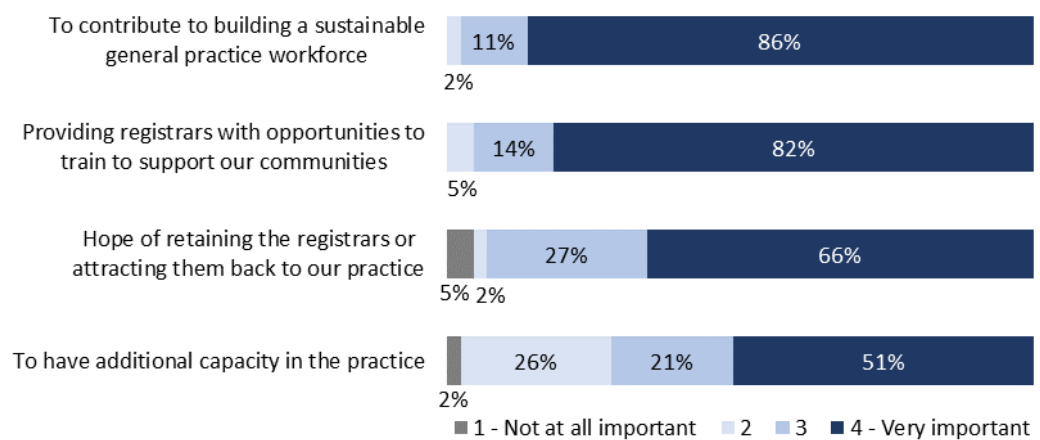


Figure 17. Accredited practice survey motivators to becoming an accredited practice on a scale from 1 (not at all important) to 4 (very important) (n=44).

Accredited practice spokespeople also described the advantages of registrars as exposing practice staff to fresh ideas. Registrars who were recent graduates held relevant knowledge and often provided learning opportunities for older experienced doctors.

Other reasons for becoming an accredited practice included providing an opportunity for registrars to experience working in a Māori provider or supporting communities with high needs.

Supporting our future GPs to experience te ao Māori and mō Māori mā Māori Kia Māori approach. (Accredited practice survey data)

7.3.3. Barriers to practice accreditation

The main barriers to being an accredited practice were meeting the requirements to become a placement provider, the cost of providing placements and capacity for supervision.

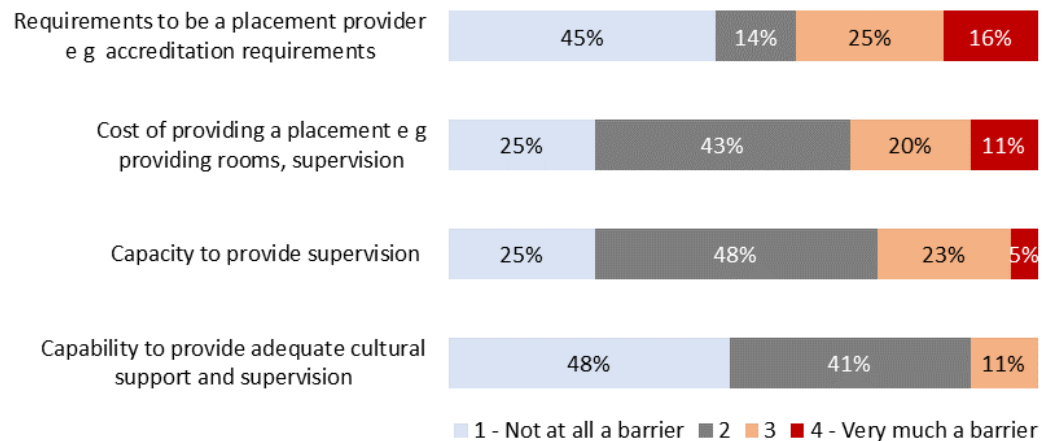


Figure 18. Accredited practice survey barriers to accreditation on a scale from 1 (not at all a barrier) to 4 (very much a barrier) (n=44).

Cornerstone requirements were a barrier for some practices and teachers. The volume of work required was described by some interviewed stakeholders as not achievable for small practices. The payment and paperwork associated to accreditation deterred some practice who wanted to provide teaching opportunities from gaining accreditation.

There have been small practices, very small rural practices who have found they do not have the capacity to put the hundreds of hours to get the accreditation to be able to keep the GP registrars and they are run by senior GPs who have a lot of experience teaching and were seen to be providing a good service but the requirement for suddenly all of this paper work. (Teacher)

Teachers also noted the lack of support from the College to complete the accreditation documents. The cost of accreditation and the expectation that practices would need to *renew it every two, three years is a huge barrier to having a registrar in practice*. Participants did not feel Cornerstone accreditation added to their ability to teach and support registrars. Some practices opted out of completing the process.

At the moment it's something like 30-40% of patients in [district] do not have a registered general practitioner and a lot of practices have decided that they don't have the time, energy, skills or capacity to do the foundation accreditation which means they can't have the registrars and the workforce isn't being renewed. I would love to see a consideration of what is actually appropriate in terms of requirements. (Teacher)

Participants discussed the missed opportunities for Māori, Pacific and rural providers who could not sustain the costs of providing placements.

A lot of the practices that [registrars] should be going to can't afford to make [registrars] practice employed. (Māori GP)

An increase in support, resource and financial investment into Māori, Pacific and rural practices was highlighted as necessary. Participants noted the need to provide consistent registrar placements so practices could plan their service delivery.

Registrar training relied on accredited practices and GPs who were able to provide teaching. Suggestions were made to support practices to have an anchored GP who would split their time between general practice and administration such as funding applications, accreditation process, and the support and safety of registrars.

The practices like the Māori, Pacific, Iwi owned and ko wai atu need consistency in the placement of their registrars so they can plan their service and those practices should be prioritised and the funding and resource in those practices needs to be upped. (Māori GP)

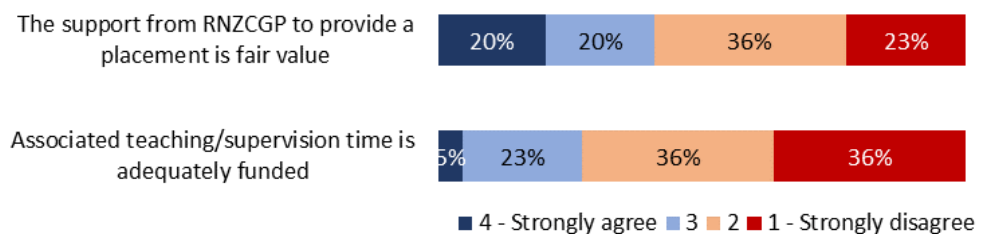


Figure 19. Accredited practice survey - ratings of support and funding from the College. Statements were rated on a scale from 1 (strongly disagree) to 4 (strongly agree) (n=43-44).

7.3.4. Financial consequences of being an accredited practice

Practices and teachers reported that having a registrar was often a financial burden. We developed a simplified model of practice financial cost and revenue to explore the circumstances in which a registrar might represent a net cost or a contribution to general practice finances.

The key assumption we make is that there are no additional enrolled patients in the practice as a consequence of having a registrar. This means that the registrar can only generate revenue from consultation co-payments. In some circumstances this can provide significant revenue, where a practice has a high level of co-payment and a substantial adult population. But there can be several factors that limit co-payment revenue. Where a practice has a low level of co-payment, particularly if they are a Very Low Cost Access (VLCA) practice, then a very high level of productivity in terms of consultations is needed to generate significant revenue. Where a large proportion of the enrolled population are children (who generate no co-payment revenue) or hold a Community Services Card (where co-payments are reduced), then the potential to generate co-payment revenue is also reduced.

We have modelled the net financial impact for VLCA practices, and for a typical practice with co-payments at \$40. We have produced results for the case in which the practice is paying a salary or equivalent of \$120,000 to the registrar, and for the

case when a practice is paying nothing for registrar income (as applies to the majority of GPEP 1 trainees). We have assumed based on interviews with teachers that the practice provides one hour per day of supervision, and calculated results for a range of registrar consultation times.

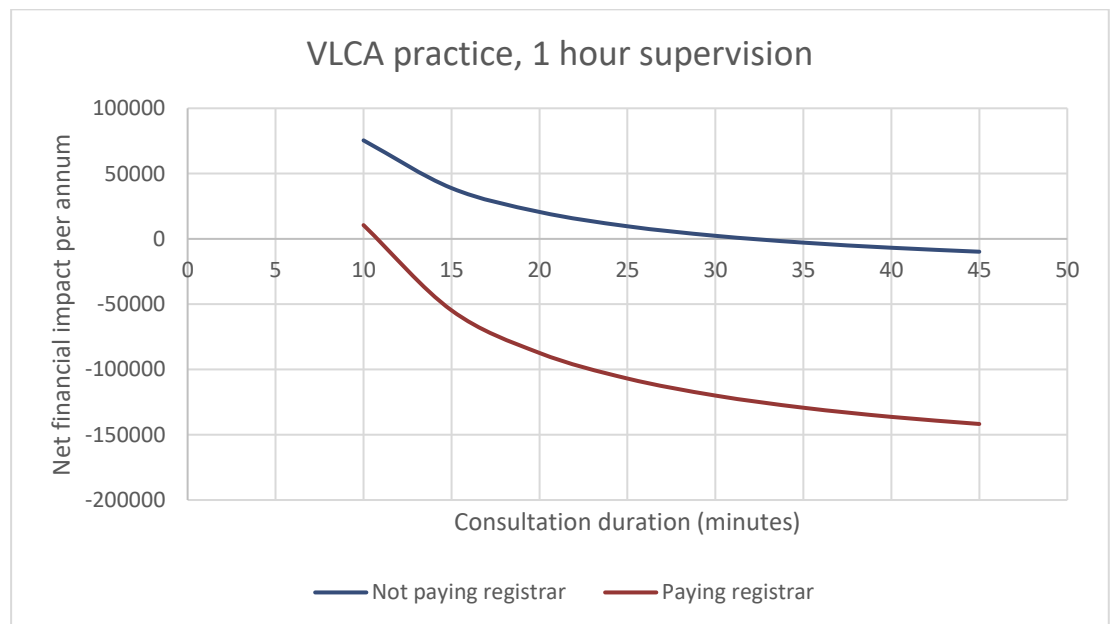
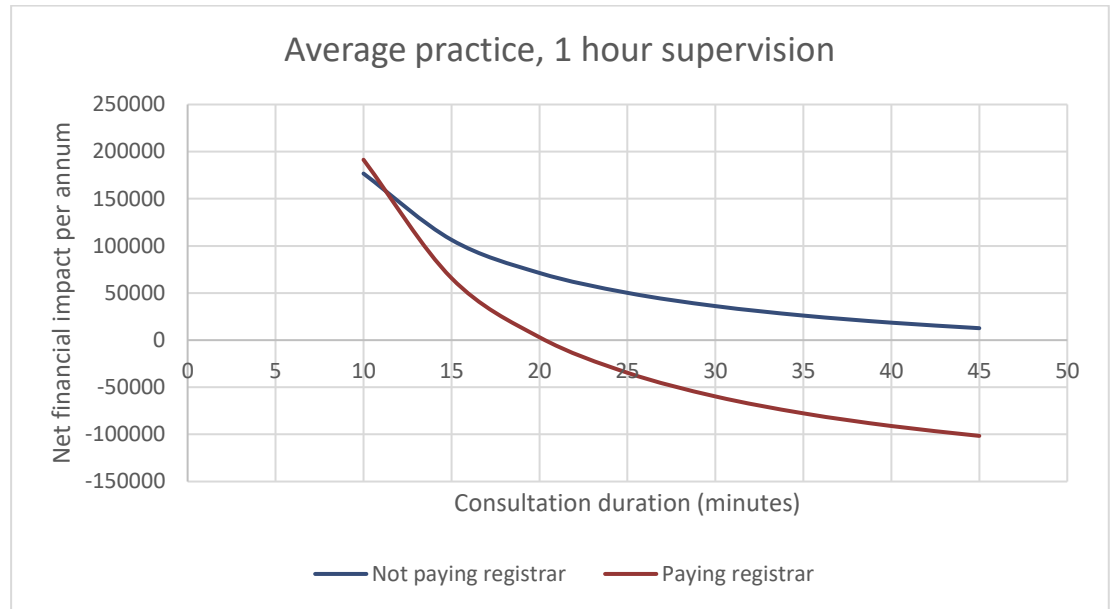


Figure 20. Financial consequences of providing a registrar placement

As might be expected, the results for the VLCA practice with capped co-payment levels are much more likely to be negative. But when paying a registrar income even

the typical practice can make a loss if consultation time is longer than about 20 minutes on average.

The specifics of individual practice financial performance will vary substantially, and the context in which practices operate will be affected by many complex factors. The way that our assumptions apply to any one practice or trainee will vary, and will also vary as trainees develop their skills and experience. But our view from considering the model scenarios is that there are many circumstances in which practices will find that a trainee is a financial cost, and that this will apply particularly in practices serving high need populations with lower co-payment levels.

8. Equity and te Tiriti o Waitangi

Key messages

There are inequitable outcomes for Māori and Pacific peoples in the current health system. Inequity of access to GPEP starts much earlier in education. Rangatahi Māori and Pacific young people are not supported to achieve the same rate of NCEA 3 passes as young people from other ethnic groups.

Shortage of Māori and Pacific GPEP registrars highlights the need to provide the best possible support for those who do enter GPEP.

A culturally competent GP workforce that includes more Māori and Pacific GPs will contribute to breaking down barriers for Māori and Pacific to access general practice and receive culturally safe healthcare. While there is a cultural component to GPEP 1, there is no cultural safety education in GPEP 2.

Cultural safety for non-Māori and non-Pacific registrars is enhanced by training placements in practices with high proportions of Māori or Pacific patients and by growing their understandings of Māori and Pacific models of care.

Māori and Pacific doctors are under-represented amongst in-practice GPEP 1 teachers. In many districts, including those with a high proportion of Māori in the population, there are no Māori practices accredited as training practices.

There are more likely to be financial barriers to being an accredited training practice for VCLA practices.

Opportunities:

Mana Taurite (Equity) must be reflected in the GPEP funding model, the employment model, support for registrars and in enabling opportunities for placements with kaupapa Māori providers²⁹ for all registrars.

Tino Rangatiratanga and Pātuitanga (Partnerships) between health sector organisations and Māori are a Te Tiriti obligation and change will not be achieved without partnerships at national and regional levels. Partnerships with mana whenua can strengthen registrar and teachers' cultural understandings and experiences. A mana whenua approach will enable a localised response or enable registrars to care for patients in a way that considers the community and context

²⁹ For the purpose of this review, we consider kaupapa Māori providers to be any provider guided by kaupapa Māori principles, tikanga and te ao Māori and with Māori governance. This includes iwi health providers.

whānau live in. The cultural component of GPEP training can sit alongside the clinical training.

Kōwhiringa includes resourcing Māori and Pacific general practices to become accredited teaching practices and supporting more Māori and Pacific GPs to be involved in teaching even if they have not achieved College fellowship. Kōwhiringa requires examining the criteria for practice accreditation and consulting with Māori practices to understand the barriers to becoming accredited practices and developing strategies to remove barriers.

Whakamarumarutia (Active Protection) requires ongoing monitoring and evaluation of strategies put in place to respond to the review.

8.1. Increasing the number of Māori and Pacific registrars

Although the pipeline to GPEP entry is out of scope for the review, it provides important context when considering the extent Manatū Hauora is meeting their Te Tiriti obligations.

Rangatahi Māori and Pacific young people are disadvantaged within Aotearoa New Zealand's education system. The National Certificate of Educational Achievement Level 3 (NCEA Level 3) is the final stage of senior secondary education and serves as a foundation for further study and/or employment. Rangatahi Māori and Pacific young people are not supported to achieve the same rate of NCEA 3 passes as young people from other ethnic groups. In 2020, 40.3% of Māori school leavers and 55.8% of Pacific school leavers attained NCEA Level 3 or UE standard compared to 81.3% of Asian school leavers and 60.4% of European/Pākehā school leavers³⁰. In 2012 data, Māori achievement rates in sciences were substantially lower than non-Māori³¹.

Medical School entry has been addressing equity through intakes of Māori and Pacific applicants and those from rural areas who may be more inclined to return to the localities they whakapapa to.

I think the focus of this should be on recruiting more Māori or Pacific doctors. A New Zealand European doctor with good cultural competence still seems to be less effective for Māori patients than a Māori doctor regardless of their degree of cultural competence. (Registrar, survey data)

³⁰ https://www.educationcounts.govt.nz/__data/assets/pdf_file/0019/208072/Indicator-NCEA-Level-3-and-UE-2020.pdf

³¹ <https://www.health.govt.nz/publication/maori-participation-and-attainment-science-subjects-aged-15-17-years-2008-2012>

It is important to develop strategies that focus on attracting the Māori and Pacific doctors leaving Medical School to GPEP training. Development of these strategies is an opportunity as part of GPEP funding.

8.2. Supporting Māori and Pacific registrars

Interview participants discussed the importance of providing wrap around support for Māori registrars as they are often isolated in practices. Māori participants discussed the importance of wānanga, networks and communication to provide added layers of support. Excluding Māori in-practice teachers, paid Māori positions comprise one lead medical educator, six facilitating medical educators, one clinical lead and one pou whirinaki to support registrars. The medical educators have responsibilities to all registrars in their regions.

Support is provided to Māori registrars through:

- The Pou Whirinaki role, who provides pastoral care and support to all Māori registrars
- Te Akoranga a Māui – the College’s Māori representative group who provide support and guidance to each other and particularly for Māori registrars
- Attempts to match/place Māori registrars with Māori practices.

We try and match our Māori and Pacific registrars to Māori and Pacific practices first and foremost. There is a matching process that we go through and that is starting to be strengthened. Previously we had Māori registrars with non-Māori supervisors... (Māori GP)

Participants commonly noted the lack of funding for any hui, wānanga or opportunity to gather as Māori doctors. Much of the support provided to Māori registrars was unpaid and often relied on Māori doctors calling in favours to different whanaunga in the profession.

I think about Māori practitioners as duly competent. They have to be competent as a doctor but they also have to be competent in tikanga, te reo, Kawa their own identity and their ability to use it in the practice. (Māori stakeholder)

The College has a Pacific chapter comprising Pacific doctors. This chapter was an opportunity for Pacific registrars to meet and network with senior doctors. It was particularly important when registrars were placed in non-Pacific practices. Interview participants noted the mismatching of registrars into non-Pacific practices. Frustration was shared around the lack of support Pacific registrars had in practices where there were no doctors who could provide a cultural lens of support.

When they do their training, and they tell us that they ask for Pacific practices they don't get matched. We have Pacific GPs being sent to Tauranga and Taumarunui and

they asked for a Pacific practice so there is mismatch. And I don't think the College understands that need to work with likeminded people who look like you, sound like you who can support you in this journey. (Pacific stakeholder)

8.3. Exposure to cultural learning and training

Cultural learning and training are essential for non-Māori and non-Pacific registrars to ensure they understand and can support Māori and Pacific patients and understand Māori and Pacific models of care.

Registrars in GPEP 1 attend a programme called Te Ahunga which is focused on hauora Māori, Te Tiriti and equitable health outcomes for Māori. Te Ahunga is hosted on regional marae over two days. This gives registrars an opportunity to learn, connect and network in their local communities. During Covid, Te Ahunga has been provided online. Formal cultural training was not available in GPEP 2/3. Suggestions were made by registrars to develop a cultural framework for GPEP 2/3.

While some cultural knowledge can be gained through courses, registrars highlighted the importance of kaupapa Māori, Iwi based and Pacific health providers who could enable exposure to cultural experiences and build their confidence through placements.

I think it is important that registrars are placed at Māori and Pacific health providers, I think that is the only way you are going to get the experience. (Registrar - interview)

Stakeholders described different levels of cultural competence across the GPEP registrars. Some stakeholders felt registrars would not practice with an equity lens and reach equitable outcomes unless they entered GPEP with an equitable approach. Some registrars described feeling confident on cultural knowledge and ways of interacting through the MIHI 501 Institute at Christchurch School of Medicine. Participants noted, the current contract did not prove an opportunity to tailor the cultural learning programme and develop cultural standards and measure of assessment to ensure registrars through GPEP 1 to fellowship met appropriate cultural standards.

There isn't enough funding [for cultural training]. Really all they get is the two days and we are not ever going to come out with someone who is equitable at the end unless they were before they went in. (Māori GP)

Similarly, registrars who had an interest in Pacific health did not have many opportunities to experience Pacific culture and participate in cultural learning.

What I worry about, the Palagi, Asian doctors that in my view if they are interested [in Pacific culture] we need to help them understand Pacific cultures, way of life, belief systems and I don't think that happens enough. (Pacific Stakeholder)

Manatū Hauora and the College also recognise the need for cultural training for teachers and medical educators. Registrars complete the Meihana programme at Medical School but teachers completed their training prior to a robust cultural component at Medical School. Each registrar intake also includes internationally trained registrars who may not have experienced meaningful cultural training in a New Zealand context prior to commencing GPEP.

Some interviewed stakeholders also expressed their concerns around cultural capability of non-Māori teachers particularly those who were supervising Māori registrars and the need to provide cultural safety training to staff.

We also need to upskill the staff members within the college who are lead MEs who can undo and do some real damage both in a clinic and in their teaching. The reality within the college it is not BAU. The College staff also need to have anti-racism training and the equivalent of cultural competency [training]. (Māori GP)

Manatū Hauora has recently provided additional funding to the College to progressively support GPEP teacher participation in the MIHI 501 programme.

8.4. Expectations under Te Tiriti

Participants commonly noted the absence of consultation with Iwi and any Māori in the development and negotiation of the GPEP contract and training programme. Some participants said the GPEP contract was not Te Tiriti compliant as it did not enable Iwi to contribute to or influence the learning that happened in their respective regions.

I mean, if we're going to be thinking about is the programme Te Tiriti compliant? You'd have to say, no, it's not. So essentially, if we're thinking of Rangatiratanga as one of the concepts of Te Tiriti, I would doubt that there's local development by hapū and Iwi in the teaching programme ... (Stakeholder)

The limited availability of placements with Māori general practices and the small number of Māori in-practice teachers did not enable non-Māori registrars to experience general practice through a te ao Māori approach. Investment into kaupapa Māori providers and cultural training was considered by stakeholders as essential for registrars to be equitable in their practice.

Seriously allowing these providers to provide kaupapa Māori/Pacific solutions for their communities and trusting them with the resources to carry out their mahi. (Registrar, survey data)

A review was suggested to increase remuneration to better reflect the realities of working in Māori and Pacific communities. Survey respondents also noted the models of care and 15-minute appointments were barriers to supporting the

complex presentations that registrars and doctors were seeing in Māori, Pacific and rural settings.

At the moment, the funding system (capitation), favours those working in wealthy NZ European urban settings. Change the funding model so that doctors working with Māori and Pasifika communities are the best remunerated. (Registrar, survey data)

9. Summary and recommendations

There is no doubt that primary care offers value for money within the health sector. There is considerable evidence that prevention, early intervention and treatment in primary care reduce the costs associated with other parts of the health sector³².

Often cited work by Starfield found that that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations³³. A 2012, literature review concluded:

In both developed and developing countries, primary care has been demonstrated to be associated with enhanced access to healthcare services, better health outcomes, and a decrease in hospitalisation and use of emergency department visits. Primary care can also help counteract the negative impact of poor economic conditions on health³⁴.

A GP Future Workforce Requirements report commissioned by the College³⁵ provided examples of cost savings through general practice:

- 10 extra GPs per 100,000 people means about 30 people a year would not die from cancer, respiratory, and cardiovascular issues.
- More GPs would save the economy \$139.6 million in health savings a year (\$150m per year in savings minus the cost of \$10.4m to train more GPs).

The GPEP funding review is focused on the GPEP funding model and the extent it is an effective vehicle to attract registrars to GPEP and to enable a clinically and culturally competent GP workforce across Aotearoa New Zealand.

A health workforce funding review in 2020³⁶, identified several issues related to the development of the workforce, including:

- The workforce not reflecting the population it serves, with low participation from Māori and Pacific

³² Bazemore, A., Petterson, S., Peterson, L.E., Bruno, R., Chung, Y. and Phillips, R.L., 2018. Higher primary care physician continuity is associated with lower costs and hospitalizations. *The Annals of Family Medicine*, 16(6), pp.492-497.

³³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/>

³⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/>

³⁵

https://www.rnzcgp.org.nz/RNZCGP/Publications/Future_of_the_Workforce_Report/RNZCGP/Publications/GP_Future_Workforce_Requirements_Report.aspx?hkey=528a23fd-6bff-4537-9d8f-288533779f38

³⁶

https://www.health.govt.nz/system/files/documents/pages/health_workforce_funding_review_-_current_state_final_25_nov.pdf

- A need for stronger leadership
- A need to respond to changing work types and demand for different skills
- A greater focus on acting in a more multidisciplinary way
- Training methods that have changed little in the past twenty years, which include a high reliance on supervision which may constrain system capacity.

There are also systemic challenges to strengthening the GP workforce that need to be highlighted to encourage sector wide responses including:

- Lower NCEA 3 completion rates by rangatahi Māori and Pacific young people
- The profile of general practice within medical schools and DHBs where those we interviewed described post-graduate doctors being discouraged from considering general practice and lack of exposure to general practice during the post-graduate years
- The ability to practice as a GP without being a fellow of the College, less intensive vocational training than other disciplines and salary differences between GPEP and other vocational programmes that all contribute to perceptions of general practice as a lesser speciality.

Meeting these challenges to the GP workforce require responses that extend the scope of the current GPEP funding model.

9.1. Equity

An equity lens has been used in developing the review conclusions and associated recommendations. The key messages from an equity perspective are:

- The equity components of training and support for Māori and Pacific registrars are 2% of the current GPEP contract.
- Māori voice and representation from Iwi is not evident in developing the contract content or in partnerships to deliver education to GPEP registrars.
- The funding model must enable stronger cultural safety education and ensure it is available and accessible throughout the entire three-year programme. Practising in a culturally safe way requires experience working with Māori patients and understanding of Mātauranga Māori. Marae days and cultural safety education sessions, while valuable are not sufficient.
- The registrar employment models need to enable registrars to practice in rural locations and at kaupapa Māori and Pacific practices. More understanding is needed about the barriers for kaupapa Māori and Pacific practices to offer placements for registrars. Strategies must be developed to respond to the barriers.

- Partnerships with mana whenua provide opportunities to strengthen registrar and teachers' cultural understandings and experiences. A mana whenua approach will enable a localised response or enable registrars to care for patients in a way that considers the community and context whānau live in (as Māori, hapū and Iwi are different in their contexts).
- The cultural components of GPEP training do not need to be delivered by clinicians.

9.2. **While GPEP 1 provides a solid educational foundation, GPEP 2 support needs strengthening**

The College provides professional leadership and develops and maintains the educational content of GPEP. Registrars, medical educators and teachers provided positive feedback about the GPEP 1 educational experience. Registrars' reasons for wanting to become GPs and teachers' reasons for providing training for registrars demonstrated a commitment to general practice, appreciation of the variation within the role and the importance of primary care.

However, those we interviewed commonly did not consider GPEP 2 provided enough support for registrars. Many suggested extension of case review opportunities through more frequent peer review sessions and one-to-one mentor sessions.

Some suggested the clinical exam should be pushed out from the end of GPEP 1 to the mid-point of GPEP 2. Pushing the exam out will have salary and employment implications in the current employment model but these could be addressed through different approaches.

9.3. **Opportunities identified by the review**

The key themes from the review identify opportunities within the GPEP funding model to improve equity and the distribution of GP training and supply.

- The contract structure and inability to move money from one component to another limit responsiveness and flexibility. There is no or limited input into contract content from policy teams, Māori and Pacific.
- The salary changes compared to DHB contract conditions is a key barrier to entering GPEP. Although base salaries are similar the terms and conditions and the employment category result in lower incomes for College employed GPEP 1 registrars. Additionally, in DHB settings registrars have opportunities to bolster their incomes through overtime payments.
- Most GPEP 1 registrars are employed by the College. College employed registrars do two six-month placements. In 2020, one-quarter were practice

employed. Registrars' described incentives for practice employment as higher salaries, choice of practice and 12-month placements. One 12-month placement limits exposure of GPEP registrars to different general practice models, different communities and their needs.

- Some registrars will complete GPEP with only limited exposure to different communities and types of general practices.
- Practice employment is challenging for some GPEP 1 registrars because of lack of understanding of their contracts and pressure for some to see more patients through shorter consultation times.
- Interviewed registrars described a conflict of interest in the College's roles of educator and employer.
- While GPEP 1 received positive feedback from registrars, registrars and teachers considered the support in GPEP 2 was inadequate. Registrars are not well prepared to negotiate their contracts with practices for GPEP 2/3.
- GPEP teachers are committed to their roles and registrars provided positive feedback about the teachers. However, teachers are predominantly male, older, Pakeha and Asian providing fewer role models for younger female registrars and Māori and Pacific registrars.
- Interviewed GPEP teachers felt that they were inadequately remunerated for the time they spend on supporting GPEP 1 registrars.
- In many circumstances practices with low co-payments are likely to find a registrar financially costly, further limiting diverse training opportunities for registrars.

9.4. Strategies to improve the GPEP funding model

Promotion of general practice	<p>The College, Manatū Hauora, Te Whatu Ora/HNZ and Te Aka Whai Ora/Māori Health Authority develop a communication strategy with the aim of positive marketing of general practice and diverse stories of high needs, rural, Māori, Pacific and urban practices.</p> <p>Promotion was identified as a way to showcase the diversity and range of work in general practice which was generally unknown by registrars in the hospital system. Promotion is necessary in undergraduate and post-graduate settings. Strengthening of community-based attachments for post-graduate doctors will help to promote general practice.</p>
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The funder and employer	<p>Funding for general practice training is from the ‘public purse’ as for other specialist vocational programmes. Training for health professionals across many groups is publicly-funded despite varying proportions of income coming from providing private sector services.</p> <p>Separating registrar employment from the College’s role as the educator has the potential to make it easier to place GPEP registrars on the same footing as other registrars and to avoid differences in experiences between College and practice employed registrars. The College, as the professional body, would retain professional leadership of GP training, responsibility for the educational content and quality assurance. The College would continue to require funding for pastoral care provided by medical educators in addition to the delivery of the training and education component of the programme</p> <p>Aligning employment terms and conditions for GPEP registrars with registrars in other vocational programmes would remove the main barrier to entering GPEP. Te Whatu Ora/HNZ as the employer of registrars in DHB vocations seems best placed to also employ GPEP 1 registrars.</p> <p>In other vocational programmes registrars remain in DHB employment. There are advantages in further funding an educational component of GPEP 2 which will require payment for educational and supervision time either to registrars or practices. The clinical exam could be pushed into GPEP 2.</p> <p>In general practice, the GPEP 2 registrars are likely to be generating practice income in some, but not necessarily all, practices. A standard contract for GPEP 2 would be a benefit for registrars but would require consultation with practices. Te Whatu Ora/HNZ contribution to registrar salaries in VLCA practices would contribute to building diversity of placements.</p>
GPEP Funding contract	<p>The GPEP contract will need to be revised based on the review recommendations. The contract content would be strengthened by input from policy teams, Te Aka Whai Ora/Māori Health Authority and Pacific advisors within Manatū Hauora and the College.</p>

	Over time, shifting the balance from the current transactional contract to a more outcomes focused contract would increase flexibility and ability to respond to emerging needs.
Education programme development	Curriculum development and quality assurance remain the responsibility of the College, as for other vocational programmes.
Delivery of GPEP 1	<p>The College is responsible the delivery of the vocational programme including contracting medical educators, the accreditation of teaching practices, quality standards, and assessments.</p> <p>The review indicated the potential to strengthen GPEP by:</p> <ul style="list-style-type: none"> • A focus on enabling more Māori and Pacific medical educators. This may require separation of teaching and mentoring/cultural support functions. • Supporting Māori and Pacific and small rural practices to become accredited. Considering other opportunities for GPEP registrars to practice in settings under supervision of a teaching fellow such as marae and workplace clinics and clinics in school settings where a fellow may not always be available. • Expanding the support provided to registrars in GPEP 2. Registrars suggested one on one or small group sessions and an out of practice mentor they could contact for case discussions. • Developing regional placement programmes where local Iwi, local stakeholders such as NGOs, general practices and DHB can contribute to providing registrars with a breadth of experience about a region where they may plan to practice.
Equity and diverse experiences – regional partnerships	<p>While cultural safety education provides a foundation, on the ground experience in diverse settings with diverse communities is the most powerful way to build understanding.</p> <p>Regional partnerships offer opportunities for registrars to have a breadth of experience of different communities and general practices. The process for forming regional partnerships involves health sector organisations (Te Whatu Ora/ HNZ and Te Aka Whai Ora/MHA nationally and PHOs or similar regional organisations) alongside the College. They may also remove relocation barriers</p>

	<p>by providing registrars with certainty of a 12 to 24-month regional placement.</p> <p>Registrars select a region where they are likely to want to live and work long-term. Regional partnerships with DHB/PHO/mana whenua are formed as the basis for developing a placement programme. The programme may include a rotation around a selection of providers who while predominantly general practice will also include other primary care settings such as iwi providers, marae-based health services.</p> <p>Participating general practices will have strengthened support, and more certainty they will have a registrar.</p> <p>A regional pilot programme could be set-up and evaluated to inform national development.</p>
Placement provider contracts and funding	<p>General practices vary in their structure, nature and the populations they serve. This variation must be considered in the contacts held between the placement providers and the funder.</p> <p>Placement funding is inadequate for VLCA practices and minimally adequate for some others. Consider different payments depending on practice co-payment rates.</p>
Administration of GPEP	<p>The review is not able to conclude whether the administrative funding is adequate or GPEP administration is inefficient or both.</p>

9.5. Recommendations

Barriers to recruitment:

Recommendation 1a: Te Whatu Ora/HNZ is the employer for GPEP registrars and GPEP registrars' salary and employment terms and conditions are aligned with registrars in other vocational programmes.

Recommendation 1b: General practice is promoted in the under-graduate and post-graduate years as an important and valuable vocational choice.

Enabling a clinically competent workforce

Recommendation 2a: Te Whatu Ora and the College work together to consider expanding the educational component of GPEP 2 and deferring the clinical exam until GPEP 2 and the associated funding implications.

Recommendation 2b: Te Whatu Ora/HNZ and the College consider employment options for the educational component of GPEP 2.

Recommendation 2c. The funder and the College develop strategies to support wider representation of rural, Māori and Pacific practices to become accredited practices.

Enabling a culturally competent workforce

Recommendation 3: Explore and address barriers to Māori and Pacific participation in GPEP training.

Regional training programmes

Recommendation 4: Health sector organisations and the College consult with mana whenua and other regional partners to explore opportunities for regional placement programmes to extend coverage and improve cultural safety education and understanding of rural localities.

The GPEP contract

Recommendation 5: A reviewed GPEP funding contract with a focus on partnerships to achieve change.

9.6. Overview



Appendix One: Review questions

	Manatū Hauora Ministry of Health funding contract is an effective vehicle to enable the RNZCGP to attract registrars to GPEP training and to produce a clinically and culturally competent general practitioner workforce
Funding enables equitable access for practices to be included as placement providers	<p>What are the trends in registrar placements? How are placement requests prioritised? What are the advantages and challenges to different types of organisations in providing placements for GP registrars (costs, logistics, capacity to provide supervision, teacher and practice accreditation)? What are registrars' experiences in placements in different types of organisations? What are the facilitators and barriers to attracting GPEP registrars to rural general practices and primary care providers supporting Māori and Pacific peoples? Does the funding adequately support sustainable rural placements and the breadth of experience needed by registrars working in rural locations (permanent relocation supplement, incentivised model)?</p>
Funding enables placements with appropriately trained supervisors and positive registrar experiences	<p>Does the funding allow for adequate access to cultural training and support for supervisors and registrars that meets Te Tiriti obligations (access to language, culture, cultural competency-Meihana Model, Mihi 501 training and safety training)? Does the funding model allow for adequate access to cultural training and support for registrars and supervisors to meet the needs of other ethnic groups including Pacific peoples?</p>
Funding enables employment of registrars	<p>What are the GPEP employment models? Who are the employers? What impacts do different employment models have on completion, placements and registrars' experiences? Does the employment model attract registrars (Māori, Pacific and those who want to work in rural locations) to GPEP? What are the advantages and challenges of different employment models to developing a sustainable GP workforce in all Aotearoa locations (including comparison with other vocational options)?</p>
Funding enables RNZCGP to attract registrars	<p>What are the trends in registrar participation in GPEP? What are the facilitators and barriers to those completing post-graduate years to selecting general practice as a vocational option (e.g. pay-parity, relocation, value placed on general practice as a career choice, community commitments, career options)?</p>
Funding model enables administration of GPEP by the RNZCGP and flexibility to respond to emerging needs	<p>Does the form of the contract (components, term, flexibility) enable GPEP delivery and responsiveness to changing needs? Are the necessary people involved in negotiating the contract?</p>
Manage and administer the funding contract with RNZCGP	
MOH GPEP training funding objectives	Review questions

Appendix Two: Survey details

Demographic comparison of registrar survey responses and RNZCGP GPEP admission data (2015-2020³⁷).

		Registrar survey		RNZCGP	
		%	n	%	n
Stage	Current GPEP 1	5%	415	-	-
	Complete GPEP 1	17%			
	Complete GPEP 2+	30%			
	Fellow	41%			
	On hold	3%			
	Discontinued	1%			
	Other	3%			
	Ethnicity	European/Other			
Asian		26%	33%		
Māori		8%	8%		
Pacific		3%	4%		
Gender	Female	68%	389	59%	1,226
	Male	31%		41%	
	Another gender	1%		-	
Location of last PGY	Northland	5%	415	-	-
	Waitematā	7%			
	Auckland/Counties Manukau	18%			
	Bay of Plenty/Lakes	7%			
	Tairāwhiti	2%			
	Hawke's Bay	5%			
	Waikato	6%			
	Taranaki	2%			
	Whanganui/MidCentral	4%			
	Capital and Coast/Hutt & Wairarapa	12%			
	Nelson Marlborough	3%			
	Canterbury/South Canterbury	16%			
	West Coast	1%			
	Southern	8%			
	Overseas	3%			
Employer in GPEP 1	RNZCGP	84%	409	80%	1,141 ³⁸
	Practice	16%		19%	
	Self-employed	-		1%	

³⁷ Registration and Annual Practicing Record data from Medical Council of New Zealand 2008 - 2022; RNZCGP GPEP admission data 2015 – 2020. From 2020 onwards, GPEP starting date has been moved from Dec to Jan/Feb in the following year.

³⁸ Excluding 90 'unknown' values.